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NEW ORLEANS

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MEDICAL AND SURGICAL  
JOURNAL.

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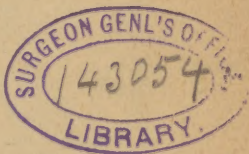
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*J. P. Davidson M.D.*

*Pallum sepultæ distat inertie  
Culata virtus.*—HORACE.

91

# New Orleans Medical and Surgical Journal.



Augustus McShane, M. D.,  
Editor and Publisher.

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## Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the first day of the month preceding that in which they are expected to appear. A complimentary edition of twenty-five reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a written order for the same accompany the paper.]

### A CLINICAL REPORT ON INTRAVENOUS SALINE INFUSION IN THE WARDS OF THE NEW ORLEANS CHARITY HOSPITAL FROM JUNE, 1888, TO JUNE, 1891.\*

By RUDOLPH MATAS, M. D., Visiting Surgeon, etc.

While the records of the Charity Hospital point to the fact that intravenous saline infusion was practised during the earlier and devastating cholera epidemic that prevailed in this city, and a dim indication is also met here and there of the direct and indirect transfusion of blood in the surgical practice of this institution (though I have no official information or record to that effect), it is, I believe, historically correct to state that no attempt prior to July, 1888, had been made to infuse intravenously a saline solution for the relief of acute anæmia.

I have undertaken, therefore, as a matter of domestic history as well as of general medical interest to present the records of all the cases that have been subjected to this procedure since that time, in this institution, and to draw from them such conclusions as the nature of the cases and the results warranted. In so doing I have gathered nineteen observations of a purely surgical character, which represent all the instances in which, after diligent inquiry, I have been able to ascertain that this method of treatment had been practised. I have, furthermore,

---

\*Read before the Louisiana State Medical Society, May, 1891.

included one medical case occurring in my own practice, which I have added to sum up the total of my personal experience with the method which is represented by five cases, all of which are embodied in this report. The other remaining cases occurred in the services of other members of the staff to whose courtesy I am indebted for the reports, especially as they are almost all unpublished histories from the ward books.

In several cases the conditions which gave rise to the indication for saline infusion were rare and of unusual interest, and outside of their therapeutic aspect are worthy of record, and for this reason I regret that in some instances I was not able to obtain more full and detailed information.

After the presentation of the clinical observations I shall avail myself of the text furnished by them to direct your attention to the indications, the advantages and life saving properties of saline infusion, believing that after the recital of several of these critical experiences you will concur with me in the belief that it is impossible to overestimate the great value of this mode of therapeutic relief in all cases in which its exhibition is appropriately called for.

## I.

### OBSERVATION I.—SERVICE OF DR. R. MATAS (WARD 8).

*Mixed Cavernous Sarcoma of Thigh, Simulating Aneurism of the Femoral—Amputation at Upper Third—Profound Shock—Saline Infusion Twice Repeated—Death.*

R. C., æt. 26, admitted July 12, 1888; Louisianian; farmer; temperate; no hereditary history; no syphilis. History: about fifteen years ago patient fell from a pine tree and drove a sharp stump about four inches deep into the flesh of the inner side of thigh. Three years ago noticed a small tumor at a spot corresponding to the apex of Scarpa's triangle. It was seen by Dr. F. (a practitioner in his native place who first examined him and who is here now and confirms the statement), who noticed a pulsation and believes he also heard a murmur. The doctor was so thoroughly convinced that the tumor was an aneurism that in sending him to the hospital later he advised the patient to carry with him a strong elastic

bandage, with the instruction to constrict the limb above the tumor in case it should burst before reaching surgical assistance.

*Status Præsens:* The patient is thin, apparently poorly nourished and careworn from anxiety, but not noticeably cachectic. He is a man of moderate height, about 5 feet 6 inches, and shows traces of a past robust and vigorous physique. On examination of right thigh, a large tumor at once attracts attention, lying with its longitudinal axis parallel to the long axis of the thigh and right over the course of the femoral.

The tumor is ovoidal in shape, projects considerably above the thigh; the skin over the tumor is tense, adherent, and over the center presents a livid color. The tumor measures in length over 9 inches, beginning at a point  $3\frac{1}{2}$  inches from Poupart's ligament, and reaches a point 4 inches above the internal condyle. The transverse diameter is over 9 inches. The tumor did not appear to spring from the bone, though it originated deeply in the thigh and, though very well outlined in the soft parts, was not distinctly encapsulated, but blended gradually with them at the periphery; in the most prominent portion of the tumor a slight bloody ooze was noticeable, owing to a fissure in the tense and livid skin. The tumor, though quite firm throughout, had, in some parts, a semi-solid feel just like a sac filled with clot. No pulsation was visible, or recognizable by palpation; no thrill; no murmur. Firm pressure over the femoral at groin causes very little difference in size of tumor, but the application of the elastic bandage reduces it considerably, fully  $3\frac{1}{2}$  inches, by measuring the circumference of the limb.

Puncture with an exploring needle draws a syringe-ful of pure blood.

This last result of the examination causes considerable hesitation in the diagnosis. The traumatic history, the statements of the first medical attendants and above all the reducibility of the growth by elastic compression all seem to point to aneurism; still the size of the tumor, the absence of all pulsation, thrill, murmur and above all the slight effect of the compression of the femoral above the tumor and absence of varicose veins tend to discredit the diagnosis of aneurism and rather favor that of malignant disease.



With considerable doubt in my mind as to which was the real condition, I decided to give the patients the benefit of an operation that would first clear the diagnosis, and second permit of an attempt to remove radically either an aneurism or malignant tumor.

The apparent break in the most prominent part of the tumor and its bloody discharge indicated the necessity for prompt action. Therefore, on July 14, 1888, the patient was taken to the amphitheater, where, with the aid of Dr. Laplace and other members of the staff, the patient was anesthetized (chloroform followed by ether) and an Esmarch bandage applied from the foot to the groin, where it was secured just below the groin. An exploratory incision was now made, following the long axis of the tumor, which at once penetrated to the center of the growth and revealed its true neoplastic character. The appearance of the section, however, was rather novel. As the knife entered the tumor a considerable amount of dark venous blood spurted out in a surprising manner.

Sponges were instantly applied, and as they were cautiously removed it was seen that the hemorrhage had stopped, and that large cavities existed in the tumor, which had evidently contained the blood that had given rise to the alarming hemorrhage.

It was evidently a cavernous growth, the large spaces being occupied by a serous, in some by a colloidal, and in most by a venous fluid. The caverns were hollowed in a stroma consisting of mixed osseous, chondroid and soft sarcomatous tissue.

In attempting to dissect the integument from the surface of the tumor it was found that the two were thoroughly adherent throughout the convex surface of the growth, and that a very large loss of skin would have to be incurred, even if the tumor allowed of enucleation in its deeper surfaces. On further exploration it became evident that the whole femoral sheath was involved and imbedded in the neoplastic mass. The tumor, however, appeared to be independent of the femur. In the presence of the complications, it was plain that conservatism was out of the question, and I decided to amputate

the thigh at its extreme upper third. Fearing that any slip in a constrictor at the thigh would prove fatal to the already exhausted subject, the ligature of the common femoral at the level of Poupart's ligament was undertaken and quickly accomplished. The elastic constrictor was now removed and the thigh amputated by a short anterior and long posterior mixed flap amputation (Lister's).

The hemorrhage was comparatively slight (not over three ounces) the vessels in the posterior flap being readily controlled with the able assistance of Dr. Laplace. The patient was kept under the influence of the anæsthetic (chloroform followed by ether) over one hour and fifteen minutes.

Notwithstanding the really small loss of blood (excepting that first loss when the loculi of the tumor were first opened) the patient was in a condition of profound shock when he was placed in bed; the pulse being then very small, shallow and rapid. Brandy and ammonium carbonate were administered and heat applied to the body and extremities. The patient recovered consciousness in the course of an hour and spoke intelligently; he vomited, or rather strained, with nausea considerably.

Six hours after the operation I visited the patient and found him perfectly rational and talkative, though profoundly prostrated, the pulse being intermittent and exceedingly shallow and rapid. Notwithstanding the persistent application of heat the patient was growing colder, and a clammy sweat bathed the surface. I now decided to try the effects of an intravenous saline injection.

Two pints of a common salt solution, made by boiling one drachm of common salt in a pint of distilled water, were slowly injected into the right median basilic. The fluid was infused warm (about 100° F.) A few seconds after the injection had commenced the patient gave utterance to expressions of increasing comfort and grateful well being. He had complained of a "fire" or "heat" which was consuming his vitals, "and a great, burning thirst." Now, as the water flowed into the vein, he felt as if a delightful cool wave was gently spreading over his body, and was giving him new strength and life and wonderfully appeasing his thirst. The

pulse in the meantime improved immensely; it became fuller, more resistant to the finger, then slower, and finally quite strong and regular, the pulsation having been reduced from 150 to 100, and less when the injection was stopped.

Next day, July 15, the patient had been very cheerful and expressed himself as having passed a comfortable night, but toward morning the prostration had reasserted itself and he had slept but little; he was not as thirsty as yesterday, but the extremities were cold and his pulse was evidently undergoing a change for the worse. It was again shallow, compressible and rapid, about 128-130, and showed a tendency to rapid deterioration. Nourishment—beef tea, brandy, milk, and digitalis, had been regularly given during the night and had been kept up since.

Evening.—The patient is evidently relapsing into the same condition as before saline injection, the beneficial effects of which are now no more perceptible; the pulse is practically imperceptible at the wrist and a cold, clammy sweat bathes the surface; he is manifestly sinking. I again inject nearly two pints of the same saline solution into the left median basilic. This time the pulse responds more slowly to the influence of the injection and it requires more fluid than the first time to fill it up. After the second pint the pulse, however, rallies and becomes hard and the patient revives.

The beneficial effects of this injection are more transitory than the first. The newly improved pulse is maintained only a quarter of an hour, the pulse becoming rapidly faster and weaker so that in the course of three or four hours it becomes imperceptible, consciousness lost and the patient expires in the morning of the 16th. The wound at no time after the operation gave reason for anxiety. After death the stump was found in excellent condition.

Remarks: In this case we must note (1) that the cause of the prostration was mainly shock and not hemorrhage, the latter being insufficient alone to account for death.

(2) That the man had been for a long time prior to the operation in a state of great nervous tension and worry, and that this added to the legitimate shock of the prolonged operation and were the true factors that led to the fatal result.



(3) The relief afforded by the saline infusion was prompt and decided, and without the two injections it is certain that life would have ended at least 36 hours before the time that it did take place.

(4) That not only was life prolonged, but great comfort given the patient by the saline infusions.

(5) That no attempt was made to regulate the quantity of liquid by a predetermined dosage, but that quantity injected was regulated by the visible or perceptible effect on the general condition and particularly by the pulse.

OBSERVATION 2.—SERVICE OF DR. A. B. MILES, HOUSE SURGEON.

*Stab Wound of the Right Axillary Artery—Axillary Abscess—Profuse and Repeated Hemorrhage after Opening Abscess—Syncope—Intravenous Infusion of Saline Solution—Recovery.*

“H. M., æt. 26 years, bricklayer, white, came to the hospital November 28, 1888, with large pectoral abscess and partial paralysis of left arm. Patient gave a history of having been stabbed two weeks previously; knife entering about one inch from insertion of great pectoral muscle. Abscess was opened and found to contain a large quantity of pus and blood clots. About two hours after opening of abscess patient had a hemorrhage from this wound. Compress applied and patient put to bed. Several hours later a second hemorrhage occurred, and like the first appeared to be venous in character. Compress was reapplied more firmly, and hemorrhage temporarily checked. Patient complained of intense thirst and was given to drink warm milk and tea. Three hours later a third hemorrhage occurred, much more profuse than either of the others, and unmistakably arterial. Patient was almost in a state of collapse.

“Dr. Miles was summoned and decided to ligate bleeding vessels immediately, as compresses would not check the hemorrhage. On opening the axilla the knife was found to have divided the median nerve and cut half through the axillary artery, which was gaping wide and bleeding profusely. Hemorrhage was controlled by pressure upon the subclavian and a ligature put around each end of the wounded vessel.

\* \* \* \* \* Patient's pulse was now 170 per minute and scarcely perceptible at wrist. At the suggestion of Mr. Borde, R. S., one pint of saline fluid (5i to pint of warm water) was injected through the median basilic vein. This had an immediate and beneficial effect; pulse became full, more regular and less frequent.

"Patient was taken back to the ward. No further hemorrhage occurred. Wound had almost healed and he will soon be restored to his normal state of health.

"There is no doubt that the injection had much to do with saving the patient's life. The hemorrhage had been profuse, and there was scarcely blood enough in his body to stimulate the heart to proper action. \* \* \* In this case, as soon as the fluid was injected a marked change was perceptible."

[Extract from hospital report by Dr. E. D. Martin, then Ambulance Surgeon, Charity Hospital, in New Orleans MEDICAL AND SURGICAL JOURNAL, February, 1889.]

OBSERVATION 3.—AMBULANCE CASE, ATTENDED BY DR. A. B. MILES.

*Idiopathic Epistaxis.*—Simply a note in the preceding report by Dr. Martin to the effect that infusion had been practised in the case of a little girl, æt. 12, who had lost so much blood from nasal hemorrhage, that no pulse could be detected at the wrist. Half a pint of saline fluid was injected and almost immediately the pulse was restored, the patient recovering permanently.

OBSERVATION 4.—SERVICE OF DR. R. MATAS (WARD 2).

*Syme's Amputation for Tubercular Arthrites of Ankle and Tarsus—Secondary Hemorrhage—Syncope—Intravenous Injection of 12 oz. of Saline Solution—Recovery.*

J. C., negro, male, æt. 42. Admitted in ward 2, July 5, 1889. Ankle and foot very much swollen; pus in the ankle, one or two sinuses leading to tarsal bones. Shortly after admission Syme's amputation was performed. The cavity of the stump is stuffed with iodoform gauze, the operation having been performed with careful antiseptic and aseptic precautions.

There were few spouting vessels after the removal of the Esmarch, but more than the usual general ooze. Hot water sponging appears to control this. The day after the operation the dressings are removed because of much soaking with blood. On removal of gauze considerable hemorrhage in region of posterior tibial which seemed to be of a venous character. The interne of the service packs the wound carefully with iodoform gauze and apparently the hemorrhage is arrested.

The dressing is removed two days after and is still found considerably soaked with blood. In removing the dressing serious hemorrhage again takes place, which still presents the same dark color; packing again resorted to and with apparent success. Owing to continued oozing Dr. M. removes the dressings and makes a careful search for a bleeding vessel, but the attempts made to control the points of greatest oozing with catch forceps fail, and owing to excessive pain complained of by the patient the attempt is abandoned and a firm tamponnade and dressing to the stump is applied, while preparations are made to administer an anæsthetic and permanently arrest the hemorrhage by ligating the bleeding points. Before the anæsthetic is administered the patient sinks in syncope, with a faint, collapsed, irregular pulse, the body being bathed in a profuse cold and clammy sweat. Stimulants, ether, auto-transfusion by bandaging the extremities, digitalis and brandy, hypodermatically, are resorted to promptly, but the patient gives no sign of rallying, and death appears imminent from collapse. Infusion is now appealed to; the left median basilic is exposed and twelve ounces of the saline solution (warmed) same as used in Case 1 are injected. The effect is magical; the pulse improves, *pari passu* with the flow of the solution in the vein, and the patient awakens rapidly, expressing himself as infinitely improved. The pulse having been brought from 150-160 to 90.

The stump was not touched; no further search made for bleeding points, as no further tendency to hemorrhage was manifested by stump from that day.

This patient finally left the hospital completely restored to health and walking on a very firm and excellent stump.—[From notes furnished by Dr. Saizan, R. S., then interne of service.]



## OBSERVATION 5.—SERVICE OF DR. A. B. MILES.

*Gunshot Wound of Arm and Head—Meningitic Symptoms—Profuse Epistaxis—Saline Infusion—Transitory Benefit—Death.*

J. B., male, æt. 32, admitted April 15, 1889. The wound in the arm was of little consequence. The wound of the head very serious, the ball penetrating below right orbit, and ranging upward and inward, passing deeply to base of skull, probably penetrating through the basilar process of occiput. Some pieces of bone were removed through wound in face; the eye did not appear to be injured, yet the patient had been blind since the injury; he could not even see a candle held before him. There had been some epistaxis on admission. Temperature for a week following admission oscillated between 102 deg. and 104 deg. F., but was declining, when a tremendous epistaxis occurred. The posterior nares were plugged and the hemorrhage finally stopped. The next day it commenced again in spite of plugging, and as he was sinking from vascular depletion, Dr. Bloom, assistant house surgeon, infused over three pints of an extemporized saline solution into the arm. While the injection was flowing the patient appeared to rally, but Dr. Bloom discontinued the injection when he saw almost the pure and colorless salt water coming through the nose. The vascular depletion appears to have been extraordinarily complete, and it is almost incomprehensible how the patient survived long enough even to receive the intravenous injection. Notwithstanding this profound oligohæmia it is remarkable that the temporary plethora produced by the infusion kept the patient alive for several hours after the operation.

It is much to be regretted that no autopsy could be obtained in this case, and that the true cause of the tremendous and fatal epistaxis could not be positively ascertained; still the venous character of the blood and the course of the ball lead the attendants to suspect the hemorrhage to come from one of the sinuses at the cranial base.

Strange to state, the amaurosis which had existed on admission disappeared some time before death, as the patient

could see plainly before the epistaxis took place, just as the fever began to decline. No autopsy was granted in this case.—[From notes kindly furnished by Dr. Cocram, then interne, and Dr. Bloom.]

#### OBSERVATION 6.

##### *Avulsion of Right Arm by a Propeller After Falling from a Skiff into the River.*

[Ambulance case attended by DR. BLOOM, Assistant House Surgeon.]

A white man, aged about 50 years, was upset while in a skiff in the Mississippi river and was caught by the rapidly rotating propeller of a steamer. The right arm was completely torn away in a perfectly circular manner about the middle third of the arm. The patient had lost a very large quantity of blood and was nearly drowned when rescued. When brought to the hospital he was practically pulseless from the profound shock, anæmia and asphyxia. Dr. Bloom availed himself of one of the large gaping veins in the stump, and, after securing the main arteries, injected about 20 ounces of extemporized saline solution. The pulse was temporarily restored, and while the vascular distention lasted the patient appeared to rally and improve. The tonic action of the injection was not sustained, however, as the patient again sank and died several hours after the infusion. In this case shock appeared to be the prominent factor in determining the *exitus letalis*. The temporary and decided benefit of the infusion in this case was very marked, as the patient was practically dead when brought to the hospital.

[This case is reported from a verbal communication of Dr. Bloom].

#### OBSERVATION 7.—SERVICE OF DR. E. LAPLACE.

##### *Overlapping Fracture of the Femur—Refracture with Chisel through External Incision—Profuse Venous Hemorrhage—Grave Syncopal Symptoms—Saline Infusion—Recovery.*

This case is reported in detail by Dr. E. Laplace, visiting surgeon, who performed the operation, in the *Medical News* for November 2, 1889. In this case the hemorrhage appeared to come directly from the chiseled bone, and the beneficial effect of the injection was truly remarkable. Sixteen ounces of the saline solution were injected.

## OBSERVATION 8.—SERVICE OF PROF. E. S. LEWIS, M. D.

*Ovarian Fibro-cystoma—Ovariectomy—Hemorrhage and Shock during Operation—Threatened Collapse in Spite of Energetic Stimulation—Saline Infusion—Recovery.*

L. F., white, age 43, admitted in hospital Oct. 29, 1889. Abdominal tumor of three years' duration. The tumor had attained enormous proportions, interfering with respiration, digestion and defecation. Patient exceedingly weak, emaciated, with a very poor, small, pulse at time of operation. Operation performed about ten days after admission by Prof. Lewis. The cyst was multilocular and contained over (?) gallons. It was universally adherent. In consequence of these adhesions much unavoidable hemorrhage occurred and operation prolonged.

At the conclusion of operation, the pulse could not be felt at the wrist; the arteries of the neck appeared to be carrying hardly any blood. Stimulation with hypodermatic injections of ether, brandy and ammon. carb. and digitalis did some good while operation was in progress, but at its conclusion failed totally to revive the patient. Saline infusion was practised by Dr. Miles, and nearly two pints of an extemporized salt solution were injected into the median cephalic. The effect was magical; in five minutes her pulse could be felt at wrist, and in ten minutes could be counted very easily and beating about 86-90 per minute. The patient left the hospital December 15, 1889, perfectly restored to health.—[Notes kindly furnished by Dr. Wm. Armstrong, then interne.]

## OBSERVATION 9.—SERVICE OF DR. MATAS (WARD 2).

*Multiple Radiating and Comminuted Fracture of Cranium from Blow in Right Temporal Region—Laceration of Main Trunk of Right Arteria Meningea Media—Coma with Diffuse Cortical Symptoms—Trephining and Removal of Large Fragments of Vault—Threatened Collapse during Operation—Saline Infusion—Temporary Improvement—Death.*

B. C., negro, adult, aged 29 (about); was struck in dispute with a heavy club on right side of head. The man was struck senseless by the blow and brought in an unconscious



state to the hospital, where he was seen several hours after admission by Dr. Matas.

The patient lay motionless in apparent sleep; no stertor; could not be roused by questioning or pinching him; could swallow a little water when placed in his mouth with a spoon. By pricking skin of feet or legs reflex movements were elicited, which after deeper and more vigorous stimulation with the pin gradually extended to upper extremities. These reflex movements appeared to be particularly active in the right half of the body, corresponding to injury; the left side did not respond as actively as right when thus stimulated. There appeared to be a slight paresis of the two extremities; the pupil on the same side appeared to be a little more dilated, though both were widely dilated and responded indifferently to lights; the pulse was slightly irregular, but pretty full; no spontaneous evacuation of fæces or urine had taken place since admission.

On examination of the head it was noticed that the right eye and lids were slightly ecchymotic and puffy; the right temple also fuller than the left. No external visible wound could be detected, but on percussion a decided "crack-pot" sound was elicited over the right temporal and parietal regions. No distinct depression could be felt, nothing certainly pointed to the enormous fracturation subsequently detected. After consultation with Dr. Bloom and with his assistance I proceeded to perform an exploratory operation. After due antiseptic preparation of the field of operation a curvilinear incision was made in temporal region over the line of the superior temporal ridge, extending from the external process of the frontal to a point about half an inch above the base of the mastoid. A perpendicular incision carried down vertically to the zygoma bisected the original curved line. By these incisions the temporal aponeurosis was detached almost completely above and bisected at its most resistant portion; the temporalis was also divided to the bone and readily peeled away from the temporal fossa. As soon as this was done the extensive character of the injury was immediately recognized. The squamous plate had been completely fractured, and was the starting point of several long fissures which radiated toward the vertex—one to bregma, another toward parietal foramen, extending across

the sagittal line, and another shorter, backward in the direction of the lambda. A number of large fragments, which were readily detached, represented the squamous portion of the temporal; some of these fragments were much depressed and imbricated. All the fragments were liberated; trephining had to be resorted to in two places to facilitate the elevation of a larger piece, after the removal of all the broken fragments.

A large space, representing the squamous area of the temporal, existed in the lateral region of skull and exposed a considerable mass of clot and the underlying dura mater; this was washed out and gently sponged, and it was seen that the dura was not resistant and flabby. An incision was made through it, which allowed a little sero-sanguinolent fluid to escape and revealed the temporo-sphenoidal lobe almost in a state of pulpification. The finger could be readily pushed into the brain substance almost to the lateral ventricles. The brain substance had almost a mushy consistence. After this revelation I hastened to wash gently with warm, boiled water, replace some of the fragments and sew the wound. As the man had shown a disposition to restlessness during the operation some chloroform was given to quiet him. It was not necessary to administer much. The hemorrhage was readily controlled, as the vessels were divided by the pressure of assistant's finger and by artery forceps; the hemorrhage was certainly moderate considering the excessive vascularity of this region. Still while the sutures were being introduced the assistants in charge of the pulse remarked that the pulse was becoming very irregular, more shallow and almost imperceptible.

The patient was very cold and clammy and appeared to be in collapse, and it was plain that he was about to die on the table. Heat, stimulants and digitalis were applied hypodermatically, but without any effect. Infusion was then resorted to and I injected over 20 ounces of extemporized saline solution into the median basilic vein. The result on the pulse was extraordinary; it was reduced to its normal beat and strength, and though the patient was unconscious he ceased to present his former collapsed and moribund appearance. The dressing was finished leisurely and the patient returned to his ward.

He survived till the next day, over 18 hours after the exploratory operation.

OBSERVATION 10.—MEDICAL CASE, ATTENDED BY DR. MATAS.

*Acute Dysentery in an Aged Male Subject—Profound Exhaustion—Apparent Death—Saline Infusion—Restoration to Consciousness—Life Prolonged Five Hours.*

Dr. S., male, white, about 60 years; much exhausted by mental worry and physical work. Came to the city for treatment, suffering with a most violent and fœtid dysentery of over one week's duration. When seen by writer, patient was pinched, shriveled and cadaverous in appearance; had small, strained, mucous actions of a most offensive character and dark color every fifteen or twenty minutes. Patient had attempted to treat himself, but very ineffectually, with enemata of morphia solution and no internal treatment. Pulse exceedingly small and rapid, over 130 per minute. Placed at once on stimulants, ether and digitalis, with small doses of saline and morphia. Enemata of Labarraque's solution and suppositories of opium, belladonna and iodoform. Temporary relief. Seen with Dr. Castellanos in consultation later, next day, and strychnia added to treatment. The evacuations appear to be improved considerably, but the pulse is growing weaker in spite of the most systematic stimulation. The mind becomes perceptibly affected; some delirium with lucid intervals. The dysentery becoming apparently better, almost all therapeutic efforts are directed toward restoring the cardiac strength. At night, find patient in stupor, cold and clammy, pulse imperceptible at wrist, evidently moribund.

In response to the distressing appeals of family to try something, the writer practises saline injection, assisted by Mr. Parker, R. S. A very large quantity of saline solution is injected while the patient is absolutely pulseless in the extremities and the respiration is barely perceptible; the patient being totally unconscious. Over two pints were injected before a decided impression could be noticed in the patient, but after this the pulse came back rapidly, filling up and becoming tense and regular as the third pint was being emptied. The pulse now



beat about ninety times per minute; the respiration was about twenty-five, and the patient revived sufficiently to ask "What is the matter?" and to survey his surroundings. Nearly three pints had been injected when this occurred and the canula was withdrawn from the median basilic vein. As was feared, the beneficial effect of the injection was only temporary. In half an hour the pulse became more rapid, the lethargic stupor began to reassert itself, and the moribund state returned. Life was prolonged, however, until 2 A. M., when death took place, five hours after the infusion had been practised.

#### OBSERVATION II.

*Wound of the Internal Mammary Artery Complicated with Penetration into the Pleura and Pericardium with enormous Hæmo-thorax—Syncopal Symptoms Preceded by Great Dyspnoea—Saline Infusion—Temporary Benefit—Death.*

A. B., male, negro, æt. 25, was brought in the ambulance, suffering with a stab wound of the chest, implicating some large vessel. Much external hemorrhage had taken place at the time the stab had been inflicted. When brought to hospital patient very pale and evidently in profound shock; breathing short, rapid; pulse intermittent, very rapid and almost imperceptible. Consciousness retained. Complains of a feeling of great oppression in chest. Messrs Armstrong and Martin, Ambulance Surgeons, immediately injected an extemporized salt solution into the median cephalic. The pulse improved as fast as the fluid flowed in veins, and almost the normal rhythm and number of beats had been reached when the injection was stopped. About two pints were injected. Though the pulse was very notably improved the respiration still remained quite rapid and short. The general effect on the patient was most remarkable, he appeared greatly relieved of his previous distress and he expressed himself as being very much better. The effects of the injection were only temporary, however; the patient succumbed about four and a half hours after.

The post mortem examination revealed an enormous hæmo-thorax, caused by a completely divided left internal-mammary artery. The pericardium had also been perforated, but the

heart was intact. In this case vascular depletion, anæmia and apnœa from the complete disability (from compression) of the left lung were the causes of death. Still, in spite of these eminently lethal conditions, it can not be doubted that life was prolonged at least three or four hours.—[From notes furnished by Dr. Armstrong, R. S.]

OBSERVATION 12.—SERVICE OF PROF. E. S. LEWIS, M. D.

*Supra Vaginal Hysterectomy for Enormous Uterine Myoma of Nine Years' Duration—Profuse Hemorrhage from General Adhesions—Profound Shock—Collapse—Saline Infusion—Marked Temporary Improvement—Survival of Three Days After Operation.—Death from Exhaustion.*

(Clinical History by Dr. Saizan, R. S., then Interne of Service.)

Mr. B., aet. 46; married; Ipara. Noticed small swelling in hypogastrium nine years before admission into hospital. Admitted February 5, 1890. Tumor grew slowly the first five years, but in the last two it enlarged in a very rapid manner. The abdomen is enormously distended, and there is great interference with the respiratory functions. On February 11, 1890, laparotomy was performed under ether. Incision extended from above umbilicus to pubis; universal adhesion with abdominal walls and viscera. Much hemorrhage and time required to separate the mass from its connections. The uterus amputated on level with *cervix*; this portion being attached as pedicle to the abdominal wound. Operation lasted one and one-half hours. During the latter part of operation, and after the tumor had been removed, the patient became pulseless at wrist, pulsations barely perceptible at carotids, and could hardly be counted, and estimated at about 160 or 170. liq. ammon. carb., brandy, digitalis, etc., were injected hypodermatically, but with little benefit. The breathing was very shallow at this time, and the heart failing most rapidly.

Saline infusion was immediately practised by Dr. Bloom, who assisted Dr. Lewis. The solution was extemporized (5i—Oj). After the introduction of a small quantity of solution there was a marked improvement in the patient's general condition, the pulse commencing to show the beneficial effect first. When six ounces had been injected, the beats came

down to 104 per minute; and after eight more ounces had been infused, the pulse beat at the rate of 84 per minute, the respirations 23.

The pulse continued good for two or three hours after operation, though it again showed an ugly tendency to rise six hours after, when it rose to 130 per minute; the temperature 99 1-2° F.

On the third day, at 2 P. M., she expired apparently from exhaustion.

OBSERVATION 13.—SERVICE OF DR. MATAS—(WARD 2).

*Laparotomy for Perforating Gunshot Injury of Abdomen—Perforation of Liver, Stomach, Duodenum and Pancreas, the Bullet Lying in the Retroperitoneal Connective Tissue over the Left Crus of Diaphragm—Secondary Shock—Infusion of Saline Solution—Death—Autopsy.*

A. B., negro, male, æt. 36 or 38, brought to the hospital in the Charity wagon, Tuesday, September 23, 1890, at 10:30 A. M. The patient, a strong, healthy, muscular laborer. He stated that on the night preceding admission he had eaten a hearty supper at 7 P. M. At 11 P. M. (three hours after) he became involved in a difficulty and was shot in the abdomen, at a very short distance, with a revolver carrying a 32-caliber bullet. Shortly after the shooting he repeatedly vomited large quantities of a black coffee-ground stuff mixed with some ingesta. The vomiting was repeated often during the night and continued the next morning when admitted to the ward.

Shortly after admission he was carefully examined by the writer together with Drs. Parham, Michinard and Bloom, with the following result:

A bullet wound was found in the upper epigastrium situated at a point midway between the xyphoid cartilage and the tip of the left tenth rib. This was the only visible wound in the body. On percussion and palpation the whole epigastrium was found full, tympanitic and tender, especially in the vicinity of the wound.

The remainder of the abdominal surface appeared to be normal. The pulse was full and regular, beating at the rate of 98 to 100 per minute. Temp. 100° F. The urine clear.



Mind fully conscious and intelligent. The general condition in every way favorable.

In view of the evidence of perforation and signs of beginning peritonitis we decided that there should be no delay in opening the abdomen. The dangers of his condition were fully explained to the patient and with his consent he was anesthetized (chloroform) and placed on the operating table.

After a thorough preliminary antiseptic preparation of the abdominal surface, a slightly curvilinear incision, four inches in length, was made, starting from a point slightly below the xyphoid cartilage, extending downward in a direction parallel with the costal arch. This immediately exposed the lower margin of the left lobe of the liver, and at once exposed a perforation situated about three-quarters of an inch from the margin and one inch to the left of the median line. The anterior surface of the stomach then rolled into view immediately, presenting a perforation about the center of the body of the organ, which allowed a probe to pass into it. The stomach was moderately distended with gas. Some blood was found diffused in the peritoneum, but no perceptible ingesta. The wounded surface having been gently drawn over, the wounded area was isolated by large abdominal sponges and the wound readily closed with a few Lembert stitches. After closing this wound it became necessary to examine the posterior surface, and for this purpose the great omentum was torn through posteriorly, with the result of exposing a bullet wound which perforated the posterior wall of the stomach, which, being larger and more irregular than the first, allowed gases and ingesta to escape freely into the lesser cavity of the peritoneum.

Further examination of the lesser cavity revealed that some extravasation of blood and ingesta had taken place, though not in large quantity. It was furthermore discovered that the bullet had again perforated the ascending layer of the transverse meso-colon and had found its way into the retroperitoneal space at a point immediately over the abdominal aorta, which had, however, miraculously escaped injury. A ragged and ugly wound was also seen to involve the very terminus of the duodenum and the pancreas close to the superior

mesenteric artery, and allowing the escape of chymous matter into the peritoneal and retro-peritoneal tissues.

Further examination through an enlarged incision (two inches more) revealed considerable accumulation of blood in the infra-colic and left lumbar region. A careful search was made for a bleeding vessel, but as none was found and there being no evidence of active hemorrhage it was deemed advisable to close the duodenal wound. This was done with some difficulty owing to the great depth of the wounded parts, but was finally accomplished. The abdominal peritoneal toilette was then attended to with scrupulous attention, the whole cavity being repeatedly flushed with hot sterilized water. About one hour was consumed in this work and the patient's condition grew unfavorable. The pulse was tolerable, but meteorism of the stomach and intestines was developing visibly and causing considerable respiratory disturbance and annoying tension in the wounded area.

After carefully drying the abdomen, a glass drainage tube was inserted at the lower angle and the wound sutured. After the dressings had been completed the patient, who had been on the operating table over two hours, was bathed in a profuse sweat, the pulse over 120 and small.

The patient was now put to bed and warmed with artificial heat and hypodermatic injections of brandy. Seven hours after, the pulse was 98, very regular, strong and fine, and the temperature 100 F.

The patient was quite conscious but restless, and was very thirsty. [Every half hour the abdominal glass drain is tested with a glass syringe, and any excess of fluid in the tube is drained away, and in this manner a considerable quantity (about 4 to 6 ounces) of bloody serum is removed from the cavity; the bloody serum also flows freely from the drain into the dressings, showing its efficiency.

September 24 (second day), at 6 A. M., Mr. Fortier, interne of the service, noticed that the pulse was becoming more rapid and compressible, and patient more restless. A teaspoonful of hot water is given every hour and a hypodermic of 10 minims of tincture of digitalis. Temperature, sub-normal.

At 11 A. M. Patient is evidently moribund; stuporous state; pulse could be counted at wrist, and skin covered with a profuse sweat. I decided to infuse salt solution. With the able assistance of Dr. Bloom and other members of the house staff, over 50 ounces (about 3 pints 3 ounces) of warm salt solution (1 teaspoonful to a pint) are injected into the right basilic vein.

The immediate effect of the infusion in this case was not as favorable as anticipated. The patient was roused from the stupor into which he had fallen, but constantly complained of *thirst* and a great heat all over his body, which appeared to increase rather than diminish with the steady flow of the infused fluid. The pulse became slower but could not be reduced lower than 120 in spite of the large quantity of fluid that had been poured into the vascular system; finally the agitation and sensation of general heat increasing to even alarming extent the further injection of fluid was stopped. About ten minims each of the tr. digitalis and aromatic spirits of ammonia were injected thirty minutes before and thirty minutes after the saline infusion.

The immediate effect of the saline infusion was decidedly puzzling in this case, specially the remarkable sensation of "burning heat" complained of by the patient, and the increasing restlessness. The behavior of this patient was indeed a striking contrast to patient No. 1, who appeared to be delighted with the cool and soothing stream that diffused itself all over his body, and so kindly quenched his burning thirst.

In this case I was certainly surprised at the results, and expected that the patient would die one or two hours after the injection.

Sept. 25. Third day after operation. Much to my surprise I learned that the patient was still alive, though he had been very delirious during the night. In fact, late at night he eluded the vigilance of the night nurse and jumped out of bed, saying that he was all right and only wanted to eat and drink. He had been forced back to bed with difficulty and had been strapped down to keep him there. Of course he was now much more exhausted. The pulse is 140 and shallow, yet



the general condition of the patient, especially the mind, is apparently much better than it was yesterday either before or after the infusion of the salt water. The temperature since the operation has never risen above 100 deg. F. There has been no vomiting and no tympanites or abdominal tenderness.

In spite of all the great excitement there was no unfavorable change in this respect. The dressings were changed, but the drain allowed to remain, though partially plugged with a Miculicz's iodoform gauze drain. The condition of the wound appeared to be satisfactory.

Black coffee and Ducro's Elixir were given with tr. digitalis by enema every three hours. Notwithstanding this and other efforts at stimulation, the man succumbed at 6 P. M., about fifty-four hours after the laparotomy and about thirty hours after the infusion of saline solution.

A careful autopsy held by Dr. P. E. Archinard, deputy coroner, confirmed the condition of affairs reached at the time of the operation. The bullet was found lying loosely in the retroperitoneal connective tissue behind the transverse duodenum to the left of the vertebral column. There were evidences of slight peritonitis limited to the lower cavity and no hemorrhage.

In this case the direct cause of death was not peritonitis, not hemorrhage, but circulatory failure, which came on, not as shock comes, immediately after the operation, but fully four hours after complete and satisfactory post-operative reaction had taken place.

Furthermore, this circulatory failure appears to have been benefited by saline infusion sufficiently to prolong life at least twenty-four hours, though the immediate effects of the infusions were far from comprehensible in that light.

#### OBSERVATION 14.—SERVICE OF DR. F. W. PARHAM.

*Fracture of Olecranon—Phlegmonous Erysipelas—Disarticulation at Shoulder—Shock—Exhaustion—Saline Infusion—Death.*

(Clinical History by Mr. E. D. Fenner, R. S., Interne of Service.)

I. C. S., male, æt. 24. Patient fell and fractured the olecranon of right arm, on November 6, 1890. Arm was put upon a slightly flexed anterior tin gutter splint, which had to

be reapplied on third day on account of pain and swelling with great ecchymosis. On sixth day he returned, very pale and weak, with marked fever which was found to be due to erysipelas of the broken arm and the whole right side of the trunk. He was transferred to erysipelas ward, where he remained till November 26, when he was sent down to ward 9.

At this time his condition was pitiful. He was emaciated and very weak, with a distressing cough which brought up extremely offensive sputum. Long incision in the arm gave exit to quantities of dirty, creamy pus. The elbow joint was opened and the brachial artery exposed and its outer coat sloughing for several inches. Suspension and the bi-chloride drip was tried for two days, when it became apparent that amputation at the shoulder was his last chance. Ether was given, preceded by atropine, grain  $\frac{1}{80}$  and brandy  $\frac{3}{4}$ ss, subcutaneously. The parts were then quickly cleansed and digital pressure made upon axillary vessels. A vertical incision was made down the outer side of shoulder, and from this an elliptical cut was carried around the arm just below the joint, but not severing the axillary vessels. The bone was now rapidly disarticulated, the vessels grasped in the flap, the circular incision completed and the vessels seized with forceps.

Meanwhile the patient had become very weak. Respirations were very feeble and shallow; pulse very weak and 200 to the minute. Large injections did not improve his condition, and saline infusion was done, the stump being stuffed with gauze and covered with hot towels. After a pint of fluid had been introduced, pulse became much stronger and a great deal slower and the operation was completed, the stump being packed with gauze and a few retentive sutures put in. Patient was put to bed, and surrounded by hot cans. He died, however, in a few hours.

OBSERVATION 15.—SERVICE OF DR. SAMUEL LOGAN.

*Compound Comminuted Fracture of Femur—Amputation—Shock—Hemorrhage—Prophylactic Saline Infusion—Recovery.*

[Clinical report by Dr. H. J. Scherck, chief of clinic.]

John McC., æt. 31 years, white, was conveyed to the Charity

Hospital by the ambulance, on January 6, 1891, suffering from compound comminuted fracture of thigh, having been run over by wheels of baggage car. Before the arrival of the ambulance he had lost a very large amount of blood, so much indeed that upon examination in the amphitheatre he was nearly pulseless and unconscious; there was also an element of shock in his case, but the extreme condition was without doubt due to the hemorrhage that had taken place; his pulse could barely be felt, but it was about 190 per minute.

The assistant house surgeon considered that the operation of amputation, under the existing circumstances, would be useless, so it was determined to give him the benefit of intravenous injection of saline solution to see if his condition could be benefited sufficiently to operate. Between three and four pints were thrown into the circulation through the median basilic vein; the effect was immediately perceptible, indicated by his pulse, which soon fell to 90 per minute. It was then that amputation was performed, at the upper third of the thigh; he regained consciousness before the beginning of the operation and chloroform was administered. His general condition for several days afterward was only fair, occasionally unconscious, but after the fourth or fifth day he gained strength and his condition improved steadily. His temperature at the time of operation was  $99\frac{2}{5}$ , which reached  $103\frac{2}{5}$  on the night of the same day, but this steadily came down to normal on the fifth day.

The stump did fairly well, a small portion of the under flap sloughing; other than this there was no particular trouble with it.

This case furnishes another link in the chain of good results following the intravenous injection of saline solution. This patient would, beyond a shadow of a doubt, have died from exhaustion from hemorrhage had it not been for the injection. Again, the great and prompt effect of this agent as a reactive agent or stimulant is beyond question; further than this it is without danger and should be employed in like cases.



## OBSERVATION 16.—SERVICE OF DR. F. W. PARHAM.

*Compound Fracture of Leg Communicating With Ankle Joint—Fracture of Ribs and Destruction of Right Eye—Secondary Hemorrhage from Seat of Fracture—Amputation of Leg—Prophylactic Injection of Saline Infusion—Death.*

(Clinical history by Mr. E. D. Fenner, Interne of Service.)

Thos. Byrnes, male, 42 years, white. Patient suffered a badly comminuted compound fracture of leg, communicating with ankle joint. Several of his ribs were broken, and his right eye so badly injured as to require enucleation. Suppuration occurred, and on January 6, under chloroform, the openings were enlarged and numerous fragments of bone removed. Amputation was advised and was now urged, but was stoutly refused. On the 12th the man was told that his leg must come off or he would lose his life. He then consented to have it done next day.

During the night, secondary hemorrhage took place, and nearly drained the circulation before it was discovered, at about 7 o'clock in the morning. The man was then unconscious and almost pulseless. Digitalis was given beneath the skin, and hot bottles put around him; at 9 o'clock his pulse was somewhat better, but he was still unconscious. He was now taken to the amphitheatre and the limb was amputated just below the tibial tubercle. Prior to the operation infusion of saline solution was commenced, and continued during the operation; after about a pint had been injected in the right median basilic, the vein became occluded with a clot. The canula was removed and inserted in the other arm, into which nearly as much more fluid was allowed to flow. Digitalis and whiskey were injected, too, and under the influence of these stimulants the man regained consciousness for a while. He was taken back to the ward with a forlorn hope for life, but died in about an hour.

OBSERVATION 17.—SERVICE OF DR. E. S. LEWIS—PYOSALPINX  
*Laparotomy—Hemorrhage—Shock—Exhaustion—Saline Infusion—Death.*

(Clinical history by Mr. A. G. Bloch, R. S., Interne of Service.)

L. S., a frail, delicate woman æt. 23 years, entered the

gynæcological ward of the Charity Hospital, February 11, 1891, complaining of severe pelvic pains. Upon examination a large fluctuating tumor was found in the left side, apparently attached to the uterus; on the right was another but freely movable. The diagnosis being unquestionable, Dr. L. suggested the removal of the diseased organs as the only means of cure. Having received the consent of the patient, on February 16 she was anæsthetized and her abdomen opened. A large pus tube was found on the left side, bound securely to the pelvic floor by strong, adhesive bands. The intestines were also bound to it by similar bands, making its removal exceedingly difficult. During the process of enucleation the tube burst, and, though every precaution had been taken, a small quantity of pus escaped into the abdominal cavity. The abdominal cavity was thoroughly irrigated, the corresponding ovary and tube were also removed for disease though not near as extensive.

The pelvic and abdominal cavities were closed, a glass drainage tube left in situ, and an antiseptic dressing placed over the wound. Patient experienced no shock from the operation; she was free from pain, though no anodyne had been given. Three hours after the operation my attention was called to the patient by the nurse, who stated that blood was running through the dressing. Upon removing same I found there was a constant flow of blood through the tube; I removed this with a syringe, cleansed the cavity with hot water, and gave ergot and digitalis hypodermically.

This I found of no benefit. Every two hours two to three drachms of blood were drawn; the patient was becoming very weak and exsanguinated. Having exhausted all means of controlling this hemorrhage except re-opening the abdomen, on February 19, with the permission of the house surgeon, I proceeded to infuse salt solution intravenously, patient's pulse being 178 and her temperature  $96\frac{1}{2}$ . I injected  $1\frac{1}{2}$  pints of a salt solution into the cephalic vein; the heart immediately improved to the increased pressure, the pulse falling in fifteen minutes to 140, and changing from a thready, almost imperceptible pulse to a full, though a still compressible one. The following day patient, while being momentarily unattended, arose from her bed and ran across the

ward. Being so weak, she fell; she was put immediately to bed, but her fall was irremediable. She was badly shocked; in the fall she must have struck the drainage tube; her pulse almost disappeared, and there was a decided hemorrhage again from the wound. From that time patient grew steadily worse and died on the night of February 21. The *post mortem* showed a cavity full of pus. There was a large blood clot around the left pedicle, the intestines were infected—in fact, patient died of both hemorrhage and suppurative peritonitis.

OBSERVATION 18.—AMBULANCE CASE ATTENDED BY DR. J. D. BLOOM.

*Stab Wound of Arm at Bifurcation of Brachial, Severing Vessels and Median Nerve—Profuse Hemorrhage—Saline Infusion—Recovery.*

(Clinical history by Mr. J. J. Ayo, R. S., Interne of Service.)

Governor Jackson, colored, born in Catahoula parish, æt. 18, and for the last three months a student at the Leland University, New Orleans, was brought to hospital by ambulance, Tuesday, April 8, 1891, at about 3 o'clock in the evening. The following history was obtained: While engaged in a fight with one of his schoolmates, patient was stabbed just below the bend of the elbow. When ambulance arrived patient was bleeding profusely, and was very much exhausted, and pulseless at the wrist. A tourniquet was applied and brandy and digitalis were administered hypodermatically.

When patient arrived at hospital, Dr. Bloom's assistance was immediately called for. Dr. B. immediately resorted to saline infusion. The patient's pulse at the temporal was 130 to the minute. About thirty ounces of a solution of common table salt and water were infused. Each time that six ounces were transfused a remarkable difference was noticed in the pulse, it having fallen respectively from 130 to 114, 108, 100, 90, 84. The wound having been thoroughly examined, it was ascertained that all the important veins had been severed; also, that the radial and ulnar arteries had been cut at their origin;



the median nerve and pronator radii teres being likewise divided. All the vessels injured were ligated, the muscle and median nerve sutured, while the wound was closed and dressed antiseptically.

Patient was sent to ward, put to bed, and his arm was surrounded by cans filled with hot water. Shortly he regained his strength, his pulse never rising above 120 to the minute. Three or four days after accident, patient had fever ranging between 101 deg. and 102 deg.; this led us to suppose that pus had accumulated in the wound, and the dressings were removed. None of the sutures had united, and considerable pus escaped. Patient was afterward dressed daily, and when he was discharged the wound was nearly completely healed up, but there was slight impairment of motion in the thumb, index and middle fingers.

OBSERVATION 19.—SERVICE OF DR. MATAS (WARD 2).

*Gunshot Wound of Thigh, with Comminuted and Radiating Fracture of Femur—Dissecting Purulent Infiltration—Fourniaux Jordan's Disarticulation at Hip—Shock—Saline Infusion During Operation—Death from Shock Two Hours After Operation.*

(From notes furnished by Mr. J. J. Ayo, Interne of Service.)

Albert C., male, æt. 36, colored, laborer; native of Indiana; strong and vigorous. While on his way to New Orleans he was shot with a pistol bearing a 38-calibre ball. The ball penetrated the middle of the thigh in antero-posterior direction, shattering the middle third of the femur. When patient was admitted in the hospital, May 11, 1891, the day following the accident, the patient was immediately attended by Dr. Bloom, assisted by members of the ambulance corps. A small opening of entrance was discovered from which considerable venous blood oozed; there was no aperture of exit, the ball being evidently imbedded in the thigh. A marked semi-solid swelling of the thigh had taken place and there was considerable lividity of the limb, indicating that considerable

concealed hemorrhage had taken place. The circulation of the foot and leg was well maintained, however, and as the pulsation of the dorsalis pedis could be faintly felt it was decided that only venous hemorrhage had taken place and that the main vessels had not been directly injured. After carefully applying an occlusive iodoform-bichloride dressing to the wound, a padded Liston's splint, permitting of extension by weights and adjusted with a liquid glass dressing, was applied by Dr. Bloom, assistant house surgeon.

The next day the swelling of the thigh increased and the oozing of the blood through the opening continued, indicating that hemorrhage had continued. The liquid glass bandage which covered the thigh became intolerably tight and had to be divided to give comfort to patient and avoid risk of strangulation. The antiseptic dressing over wound was also soaked with blood and had to be removed. A flat bag of shot being placed directly over the dressing was, by its weight, able to control excess of ooze.

The general condition of the patient was comparatively fair considering the gravity of the injury, the pulse and temperature simply indicating a subdued condition of irritability, which was remarkably disproportioned to the great devastations that were subsequently revealed.

On the 20th the wound had not healed, and for the first time discharged a purulent ooze that called for immediate action.

The patient was anæsthetized (chloroform followed by ether) and a free exploratory incision carried to the seat of fracture was made by Dr. Matas. About one quart of grumous, bloody pus at once escaped through the incision, several fragments of bone were disengaged and removed by the exploring finger, which at once discovered that the pus had burrowed upward toward the adductor region and backward to the interspace between the hamstrings. It was further discovered that the femur had sustained a longitudinal fracture which split it almost in two halves and extended in a direction upwards toward the great trochanter. In the presence of these revelations, the parts were packed with antiseptic dressings and the anæsthesia stopped.

The exploratory operation had been conducted in the ward and it was now decided to take the patient to the amphitheatre where the disarticulation of the femur at the hip could be more advantageously performed. Here the patient was stimulated with whiskey and the anæsthesia renewed. The Esmarch was applied, and aided by Wyeth's needles hemostasis secured to groin. Fourneaux Jourdan's incision was adopted, the circular division of the thigh being effected a short distance above the seat of fracture. The vessels were secured without any loss of blood and the bone enucleated from the soft parts without difficulty. The disarticulation was very difficult, however, even after a complete separation of all the external ligamentous attachments. After the disarticulation the patient gave evidences of profound shock verging on complete collapse. About one and a half quart of saline solution was now infused by Dr. Bloom into the left median basilic vein. In the meantime, ether, ammonia, digitalis and brandy were exhibited liberally both *per os* and hypodermically. The patient's pulse improved very markedly as the saline fluid was injected and fell from 160 to 110 per minute.

When the pulse reached this point an attempt was made to introduce a few deep silver sutures in order to hold together the lips of the huge wound left by the disarticulation, but the patient commenced to scream with pain and had to be given a few inhalations of chloroform-ether. The effect of the anæsthetic on the pulse was immediate and most depressing, a few inhalations raised it to 140, and of course they had to be discontinued.

The wound was therefore packed with iodoform and sublimate gauze and the stump covered with the usual dressings.

The patient was quickly brought to bed and efforts made to restore him with dry heat and stimulants.

He became conscious shortly after returning to bed and pulse appeared to improve markedly. About half hour after the operation it beat at about 120 per minute and he gave encouraging evidence of positive improvement. Two hours afterward, however, he suddenly collapsed and died.



Immediate indication.	Sex & Age	Relative state of fact.	Immediate result.	Quantity of fluid.	Operators.	Nature of injury or operation.	Date.	Remarks.
1 Shock—hemorrhage.	M. 36 W.	Very good.	Death.	Oij; Oij	Matas	Sarcoma of thigh. Amp. upper third.	July 12, 1888.	Injected twice at different sittings.
2 Hemorrhage.	M. 26 W.	Very good.	Recovery	Oij	Miles	Wound of axillary art.	Nov. 28, 1888.	
3 Hemorrhage.	F. 12 W.	Very good.	Recovery	8 ozs.	Miles	Idiopathic epistaxis.	—, 1888.	
4 Hemorrhage.	M. 42 C.	Very good.	Recovery	12 ozs.	Matas	Syme's amp. Secondary hemorrhage.	July 5, 1889.	
5 Exhaustion—hemorrhage.	M. 34 W.	Good	Death	48 ozs.	Bloom	Gunshot wound of head; wound of cerebral sinus.	April 15, 1889.	Hemorrhage uncontrollable. Effect of infusion very temporary.
6 Shock—hemorrhage.	M. 56 W.	Good	Death	20 ozs.	Bloom	Avulsion of arm.	—, 1889.	Shock the dominating element of danger.
7 Hemorrhage.	M. 40 W.	Very good.	Recovery	16 ozs.	Laplace	Overlapping fracture of femur; osteotomy.	—, 1889.	
8 Hemorrhage.	F. 43 W.	Very good.	Recovery	43 ozs.	Lewis	Ovariectomy — for fibro-cystoma.	Oct. 20, 1889.	Infusion practically resurrected this patient and prolonged life 24 hours.
9 Shock.	M. 20 C.	Very good.	Death	32 ozs.	Matas	Multiple fracture of skull with laceration; of arteria meningea media.	June, 1890.	Life prolonged over 5 hours by infusion.
10 Exhaustion (acute).	M. 60 W.	Very good.	Death	50 ozs.	Matas	Acute dysentery.	July, 1890.	
11 Hemorrhage.	M. 25 C.	Good	Death	32 ozs.	Armstrong-Martin	Stab of int. mammary artery.	1890 (?)	Lesion only discovered <i>post mortem</i> .
12 Shock—hemorrhage.	F. 46 W.	Very good.	Death	16 ozs.	Lewis	Supra-vaginal hysterectomy for myoma.	Feb. 5, 1890.	Survived 3 days after infusion.
13 Shock	M. 36 C.	Unsatisfactory.	Death	56 ozs.	Matas	Laparotomy for gunshot of abdomen.	Sept. 23, 1890.	While the pulse appeared to be favorably impressed toward the end of infusion, the patient appeared disagreeably affected.
14 Exhaustion—shock.	M. 24 W.	Good	Death	(?)	Parham	Fracture of olecranon; erysipelas, suppuration. Disarticulation of shoulder.	Nov. 28, 1890.	
15 Hemorrhage—shock.	M. 31 W.	Very good.	Recovery	O 3-4	Logan	Amputation upper third of thigh.	Jan. 6, 1891.	The amputation was performed in this case <i>after infusion</i> .
16 Exhaustion—hemorrhage.	M. 42 W.	Good	Death	Oij	Parham	Comp. fracture of leg; secondary hemorrhage.	Jan. 12, 1891.	<i>Prophylactic</i> infusion; 1 pint in each arm.
17 Exhaustion—hemorrhage.	F. 23 W.	Good	Death	Oiss	Lewis	Pyosalpinx; laparotomy.	Feb. 16, 1891.	Infusion practiced by Mr. Bloch, Feb. 19, for hemorrhage and exhaustion.
18 Hemorrhage.	M. 28 C.	Very good.	Recovery	30 ozs.	Bloom	Stab of brachial at elbow.	April 7, 1891.	
19 Shock	M. 30 C.	Good	Death	Oij	Matas	Disarticulation of hip for multiple, comminuted gunshot fracture of femur.	May, 1891.	Infusion allowed patient to be removed alive from operating table.

## SUMMARY OF THE CLINICAL REPORT.

1. Total number of cases, 19.

2. Most urgent indication.\*

Hemorrhage .....	6
Hemorrhage-shock.....	2
Shock-hemorrhage.....	3
Shock.....	3
Exhaustion, acute.....	1
Exhaustion—hemorrhage.....	3
Exhaustion—shock.....	1

Total.....19

(6) Hemorrhage: 5 recoveries; 1 death (uncontrollable hemorrhage).....	= 6
(2) Hemorrhage-shock: 2 recoveries.....	= 2
(3) Shock-hemorrhage: 3 deaths.....	= 3
(3) Shock: 3 deaths.....	= 3
(1) Exhaustion: 1 death.....	= 1
(3) Exhaustion-hemorrhage: 3 deaths.....	= 3
(1) Exhaustion-shock: 1 death.....	= 1

Total.....19

Recoveries, 7; deaths, 12. Percentage recoveries,  $36\frac{1}{3}$ ; percentage deaths,  $63\frac{3}{4}$ . Sex, males, 15; females, 4. Age, from 12 to 60 years; average, 33.4 years. Race, 13 white, 6 colored. Quantity of fluid injected from 8 to 50 ounces. Immediate effects, always good, with one solitary exception, in which, while the objective result was good, the subjective sensations were not satisfactory.

[TO BE CONTINUED IN THE NEXT ISSUE.]

REFLEX EPILEPTIFORM CONVULSIONS OF GENITAL ORIGIN  
AMENABLE TO SURGICAL TREATMENT.

By DR. R. H. DAY, of Baton Rouge, La.

For the last eight or ten years many cases have fallen under my observation of infants and children afflicted with epileptiform spasms, nervous jactitations and neurotic explosions; and failing to find any systemic conditions, functional or organic, to account satisfactorily for these nervous seizures, I was led to turn my attention to the sexual organs by the following incident: I was called in the country, five or six miles from Baton Rouge, to see a white male child, 6 or 7 years of age, who was subject to frequent spells of alarming nervous agitation. On the present occasion they were so severe in

\* In specifying the immediate indications that led to the saline infusions, the writer has adopted the method of classifying the dominant indication in mixed or complicated cases, by prefixing the most obvious cause of depression in a complicated condition.

character that his parents became alarmed and sent for me. The child was calmer when I arrived. He seemed to be well nourished and appeared otherwise well. I exposed his abdomen, and in manipulating it to discover if the viscera and organs were at fault, my hand happened to touch his penis, which immediately became erect and intensely hard. His face flushed, his eyes became lustrous and he exhibited great cerebral excitement.

I took the penis between my fingers to examine more closely. I found the preface contracted so tightly as to conceal the meatus, and no efforts could retract it over the glans. A probe passed into the opening of the preface disclosed that the preface was adherent to the glans. I at once slit open the preface back to the corona, separated the adherent surfaces, with the result that the child was permanently cured of his neurotic troubles.

From this on, in all cases of neuroses occurring in infants and children, I have never failed to examine the genitals, and have frequently been rewarded by discovering the seat and cause of the troubles, and by operative measures at once to give permanent relief.

On February 6, 1891, I had a very interesting case brought to my office from an adjoining parish, that of a male white child eight months old. I found the prepuce firmly and extensively adherent, and learned that the infant since early in last January had been subject to severe spasms, and growing more frequent and distressing.

I separated these adhesions, dilated the prepuce and pushed it back over the corona. The retained smegma had become chalky and granulated with these hardened granules imbedded in the mucous coat both of the glans and prepuce, so that in removing them blood oozed from their sites. I carefully instructed the parents to keep the surfaces well cleansed, the prepuce well contracted, and vaseline freely applied to prevent re-adhesion.

On March 7, the child was brought to me again, having had a return of his spasms five days previously.

Upon examination I discovered that the parents had failed



to carry out my instructions efficiently, with the result that the prepuce was again contracted and adherent as at first.

I determined to make a thorough operation, being satisfied that the genital abnormality was the real cause of the child's spasms. I accordingly chloroformed him, slit the prepuce far back, detached the adhesions, divided the frenum, cut off the angles of the prepuce and then with a continuous fine suture brought the divided surfaces together, and gave suitable instructions as to after-dressings, etc.

As the parents of the child are quite intelligent, I addressed them a series of questions to get a clear history of the case and the relation it might bear to heredity.

The following facts were elicited: No other member of the family had had convulsions, hysteria, spells of depression or melancholy. The first convulsions, or nervous explosions occurred on January 9, 1891, and lasted thirty or forty minutes, leaving the child in a very weak state and sleepless. The child slept well after the first operation, which was performed on February 6, 1891. The nervous spells returned on March 2, 1891, three weeks after the first operation. The last operation was performed on March 7, 1891, since which time (up to April 1, 1891), the child has had no convulsions.

On May 8 the father further informs me: "When I wrote you on April 11, the baby had a severe cold, which caused him to cough a great deal; he was very irritated at times. An hour after I mailed my letter to you he had one of those convulsions. It did not last as long as the ones he had previous to that. He has had no more convulsions since, which was April 11, 1891. He is well and hearty now, and very fat. My wife in the near future will go to Baton Rouge, and she will bring the baby for you to see it.

I might here properly close this paper, but perhaps it is my duty to remark that these peculiar forms of reflex neuroses are not limited to male infants and children, but afflict also female children, the cause generally consisting in a strictured clitoris. I have seen a few cases where I was well convinced that such was the case. It has only been during the last year that my attention has been drawn to nervous troubles in female infants from genital irritation, and future research and clinical

observation must confirm or disprove the correctness of my deductions.

While discussing this obscure, but growing and important class of diseases, I can not refrain from relating my experience in connection with a case in an adult married male, the father of several children, who, from his position in society and connections, made his case one of peculiar interest to me. For several years his health seemed to be declining, poor and capricious appetite, with symptoms of dyspepsia, anomalous, nervous agitations, dizziness of the head and tremors. I tried to analyze his symptoms and trace out their cause. I could find no organic or functional disease of any of the viscera, and came to the conclusion that his increasing troubles grew out of his sedentary life, intense application to business and perhaps, at times, to improper feeding. In despite of all my efforts and the faithful observance on his part of my directions, there was no improvement, but on the contrary, a periodical aggravation of his neurotic troubles. I advised him to visit New Orleans and consult the leading physicians of that city.

He did so, and consulted several, among them Prof. John B. Elliott, M. D., who, after a thorough physical examination with negative results, lifted his shirt and discovered a contracted prepuce, tightly binding the glans penis. To Dr. Elliott's mind the mystery was solved. He said to the young man: "Get up, put on your clothes and go home, and be circumcised, and my word for it you will be cured." The young man was astonished, and expressed his non-belief in the views of Dr. Elliott. But the doctor emphasized his opinions and said "he was so confident of their correctness that he would stake his medical reputation upon the result."

The young man returned home. I verified the condition of the penis as stated by Dr. Elliott, performed the operation, and to-day the patient is well, and as closely attentive to his business as he ever was.

I had not suspected any genital trouble possible in a married man capable of fructifying the ova of the female, and hence did not investigate the condition of the penile organ to find the seat and source of the trouble, and I respectfully and

thankfully submit that Dr. Elliott has done me a great favor, and the medical profession of the State as well.

The fact that these anomalous and obscure neurotic diseases are amenable to surgical treatment, while being greatly on the increase in this and other countries makes them of peculiar interest to the medical profession, and should induce our best physicians everywhere to make them the subjects of close clinical and scientific study, and it is for this purpose that I have contributed this short paper.

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## Proceedings of Societies.

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### GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

#### APRIL MEETING.

The president, Dr. Henry Wilson, in the chair.

Dr. Wm. P. Chunn related a case of ascites, which he treated by tapping and permanent drainage with apparently good results.

Dr. B. B. Browne operated more than a year ago upon a woman with ascites, who also had an abdominal tumor, which proved to be papillomatous.

There has been no return of either the dropsy or the papillomatous growth. He referred to the many cases of laparotomy and washing out the abdominal cavity.

Dr. Geo. W. Miltenberger could not see why any malignant tumor should not be able, by irritation of the serous membrane, to cause ascites. We often see ascites without any definable cause, and when a growth did exist it seemed a very good reason for the presence of the fluid. He referred to the case of a colored woman operated upon by Dr. Neale.

Dr. L. E. Neale said that in the case of the colored woman referred to there was no assignable cause for the ascites except the presence of a sub-serous uterine fibro-myoma; at the operation he removed the uterine appendages. The growth remained but there was no return of the ascites. There was also a complete procidentia, but after the operation he was enabled to keep the uterus in place with a soft rubber ring.

The tumor gradually diminished and ultimately disappeared.



Is the exposure and irritation of the serous membrane during the operation a sufficient explanation of such an alteration in its function when the apparent cause of the ascites remains?

He thought the question eminently important and practical in its bearings and that it required further elucidation.

Dr. Wilmer Brinton remarked that in a case of cirrhosis of the liver, in a male patient, tapping for the ascites had been followed by a permanent opening which persisted until the patient's death one month afterward.

Dr. J. Whitridge Williams, in referring to Dr. Maseby's remarks, said that the ascites accompanying papillomatous growths was considered to be due, in great part, to direct exudation from the vessels of the growth. He also referred to tubercular peritonitis.

Dr. B. B. Browne exhibited a small tumor about the size of a large hickory nut, and apparently a fibroid, which he had removed from a point a little to one side of the median line and between the clitoris and urethra. It pressed on the urethra, interfering with micturition. The growth was easily shelled out and the patient did perfectly well. It was the first growth of the sort he had seen in that locality.

Dr. Neale related a case of imperforate rectum in a white male child, naturally born at full term of healthy parents. The child was puny, weighing only  $5\frac{3}{4}$  pounds at birth, and 1 inch within the anus; the rectum was imperforate. Dr. T. Harney operated upon the child when it was  $2\frac{1}{2}$  days old, very feeble and partly cyanosed. No anæsthetic was used; anus was cut through, the perineal structures laid open, the coccyx removed, the rectum opened through its posterior wall just above the imperforate part and its mucous membrane stitched to the skin just behind the original aperture. The stitches sloughed out and the large wound healed slowly by granulation. A copious discharge of flatus and meconium occurred during the operation and the tympanitic distension disappeared.

Profound shock and collapse followed the operation, the child lying motionless, the feet and lower limbs cyanosed, the face and head less so; jaw dropped, mouth opened, eyes closed, lids blue, surface temperature but little if at all lowered. No cry. The features were frequently pinched or wrinkled from pain, becoming more or less blue at irregular intervals.

In this condition the child would make no effort at suction, but would swallow two teaspoonfuls at a time of milk and brandy when poured into its mouth, rarely refusing to swallow, and never vomiting the food and stimulants which were given freely and frequently.

For nearly two days and a half did it remain in this state,

partially rousing during the administration of food or other disturbance, and again sleeping. Even after this period, when the first decided improvement occurred, the child would frequently relapse and remain in this condition for hours at a time. The first two weeks of its life was passed in this manner. The digestive and urinary apparatus functioned nominally.

From the tenth to the fourteenth day these attacks gradually diminished and ultimately disappeared.

The child is now nearly two months old but very feeble, and weighs only five and one-quarter pounds. It has been reared chiefly on condensed milk. The dense cicatrix just about the seat of the old imperforation has to be dilated daily with the finger; another operation will be necessary. No diagnosis of abnormality in vascular system could be made.

Dr. Brinton mentioned a case of a child which lived nine or ten days with an open ductus arteriosus.

He thought that no cardiac trouble could account for the symptoms in the case. The cyanosis would not clear up entirely and then recur. He did not consider the condition one of collapse. There was no feebleness of pulse or coldness of surface. The child would lie in an apparently comatose condition with no evidence of sensation, and then recover. The first attack followed immediately after the operation and evidently from shock; but after two or three days it could not be attributed to this cause. There was no chill or febrile condition.

After the child had commenced taking food he used quinine by injection and also small doses of dialyzed iron and as he believes with benefit from the latter.

He was inclined to account for the condition in this way: A very feeble child had food forced upon it for eight or ten hours and when it had taken in all it could it apparently fell into a condition similar to that of some animals, and when the supply of food was exhausted it would recover and take more nourishment. This condition entirely disappeared after the first two weeks.

W. S. GARDNER, M. D., *Secretary.*

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#### THE AMERICAN SOCIETY OF MICROSCOPISTS.

This association, now in the thirteenth year of its existence, will hold its fourteenth annual meeting in Washington, D. C., August 10, and continue in session five days. Its roll of active members contains about three hundred and fifty names, embracing very nearly every person in the United States who is at all prominent as a microscopist. Its membership consists of two distinct classes, viz: professional men

and students of the natural sciences, who use the microscope in their daily avocations as an instrument of research, diagnosis, or precision; and amateurs, or those who find pleasure and profit in the revelations of the instrument. Many of the latter class, from having early chosen special lines of study and investigation, have acquired high reputations in their respective departments of microscopical research. In its earlier years this class predominated in the membership of the society, but at present the professional element is largely in excess.

The qualifications for membership are very simple. The applicant must be a respectable person socially, and interested in the use of the microscope.

The advantages of membership are dual in their nature, *i. e.*, general and social, or those which accrue to the individual from associations with others engaged or interested in the same pursuits in any and all walks of life; and special, in that the meetings of the society are to a certain extent educational in their nature. In the "Working Sessions" experts in every department of microscopical technology are engaged in giving manual demonstrations of the details of their lines of work; in the informal evening "conversaciones" the room of every worker who has anything special to exhibit or demonstrate, is open for the reception of all those who wish to witness the demonstration: finally the *soirée* affords an opportunity of displaying, for the benefit of the members, as well as the public generally, all that is most beautiful, interesting and instructive in the cabinets of laboratories of the exhibitors. Of late years the *soirées* have been attended by many thousands of visitors in every city in which the society has met, and have been regarded as distinguished socials as well as scientific events.

The dues are trifling, only \$2 per annum, and in return the member gets a volume of the Annual Proceedings, which costs very nearly this amount. These proceedings are elegantly and profusely illustrated with photo-engravings, autotypes, chromoliths and wood engravings, done in the highest style of art. There is scarcely a subject in the whole range of microscopical work, upon which information may not be found by reference to the indexes of these volumes, and collectively they form a library of microscopy full of invaluable matter to the student and worker.

The railroads have of late years extended excursion or convention rates to and from the places of meeting, and, although no arrangements have as yet been definitely made, we can assure our readers that the Washington meeting will be no exception to the rule. Indeed, it is probable, from the



fact of the meeting of the American Association for the Advancement of Science in Washington, only three days after our adjournment, that a more than usually advantageous arrangement may be obtained.

The museums and libraries, as well as the many other objects of interest of the National Capital and its surroundings, will be open to the visits of the members, and special facilities for seeing them will be accorded.

Special hotel rates will also be secured. An announcement of the railway fares, hotel rates, etc., will be made hereafter.

In view of the facts related and from assurances that we have already received we are justified in saying that three will be present the largest number of old members of the society ever in attendance at an annual meeting.

We invite and urge upon all persons, professional or amateur, interested in microscopy and not already on the rolls, to send in their applications for membership to the Secretary, Dr. W. H. Seaman, No. 1427 Eleventh Street, Washington, D. C. The application should be accompanied by \$3.00 which is the initiation fee, and one year's dues. As it is more than probable that the initiation fee will be increased in the near future, it will be to the advantage of all who contemplate membership to send in their applications before the next meeting.

Any further information concerning the society or the approaching meeting may be obtained on addressing any of the undersigned. Frank L. James, President. Box 568, St. Louis. W. H. Seaman, Secretary, No. 1424 Eleventh St., Washington, D. C. C. C. Mellor, Treasurer, No. 77 Fifth Ave., Pittsburgh, Pa.—*St. Louis Medical and Surgical Journal*.

## Correspondence.

STATE BOARD OF HEALTH OF KENTUCKY. }  
EXECUTIVE OFFICE, }  
BOWLING, KY., June 19, 1891. }

*To the Editor:* I am instructed by this Board to transmit to you for publication the following self-explanatory resolution which was adopted at its recent meeting held in Louisville:

*Resolved,* That the secretary be instructed to place upon the list of medical colleges whose diplomas are to be certified and endorsed for registration under the laws of this state, only such colleges as shall, after the session of 1891-92, exact of matriculates and graduates a minimum of requirements not less than those required by the American Medical College Association. Very respectfully, J. N. M. GUNACK, *Secretary*.

## BIOGRAPHICAL SKETCH OF DR. J. P. DAVIDSON.

[We are indebted to Dr. Davidson's daughter, Mrs. R. L. Robertson, for the following notes. We append also the report of the Committee on Necrology of the State Medical Society.—*Editor.*]

Dr. John Pintard Davidson was born in Pinckneyville, Miss., December 8, 1812. He was the son of Dr. Richard Davidson, of Virginia, a surgeon in the United States army, who came to New Orleans in 1804 and attained eminence as a practising physician. His mother was Eliza Noël Pintard, daughter of John Pintard, a Huguenot, prominent in the early history of the city of New York. Dr. Davidson received his degree of M. D. at the University of Pennsylvania in 1832. He returned immediately to New Orleans and entered the Charity Hospital. He commenced life by opening a drug store at the corner of Carondelet and Delord streets, in the two-story brick house which still stands there and which has been occupied as a drug store ever since. He subsequently removed to Rapides parish, at the solicitation of some of the planters of that parish and the town of Alexandria, where he soon built up a lucrative practice and endeared himself to the entire community, white and black. He was the typical physician, friend and counselor, frequently performing the duties of nurse and physician, comforter and pastor—even baptizing infants and burying the dead.

At the outbreak of hostilities between the North and South, Dr. Davidson went out as captain of the Alexandria Rifles, Crescent Regiment, commanded by Col. Marshall J. Smith. The greatest excitement and feeling were displayed at his departure. Special services were held at the churches and mass was said at the Roman Catholic church once a month for him during his absence. Although a Protestant, he was broad and liberal and respectful to all creeds. After the battle of Shiloh, Gen. Bragg tried to prevail upon him to return home and try to mend his own health which had become impaired at Corinth. This he refused to do; but finally Gen. Leonidas Polk, his warm personal friend, learning of his illness wrote to him advising him to return home where he was so valuable. He resumed his practice in New Orleans immediately after the war.

During the epidemic of yellow fever in 1875, at Shreveport, he was one of the experts selected with Drs. Bruns and Choppin to be sent to that place. He was also sent to Brunswick, Ga., as an expert on fever and also sent to the plantations below New Orleans, when the National Board of Health pronounced the fever prevailing to be yellow fever. Dr.

Davidson declared the fever at both places to be "rice fever," a fever peculiar to those living on and cultivating rice plantations. This difference of opinion produced considerable feeling on the part of the National Board of Health. Dr. Davidson was also Hon. Past Medical Examiner of Chalmette Council No. 801, American Legion of Honor. He also occupied the following positions:

President of Orleans Parish Medical Society; President of State Board of Health in 1880 (resigned before the close of the year); Chairman of Board of Medical Experts on Yellow Fever; a member of the Red Cross Society of Louisiana.

He was a man of large-hearted charity, and gave much of his time and service to the cause of humanity. He was for many years the visiting physician of the Jackson Street Orphan's Home, and also for the Trinity Benevolent Association—all gratuitous. He was a man who cared not for fame; he was not an egotist. He was loved and esteemed by all. To those whom he attended professionally he was more than a curer of pains and ills. He was cheerful, genial, always inspiring hope for the best, and in trouble gave sympathy and consolation from the depths of his generous heart. It was his lively christian charity and goodness of heart that drew and bound him to his people, and his influence was felt wherever he went.

One remarkable trait was his forgetfulness of himself when the lives of others were concerned. For instance, about the year 1848 or 1849, Asiatic cholera broke out on the plantation of Mr. Calhoun, some miles above Alexandria, on Red river. Two of the physicians in attendance had died of the disease, and everyone was panic stricken. He was called in, and in opposition to all his family could say took up his abode there, and upon investigation, found that the large number of slaves on the plantation were being fed on rotten meal; he at once separated the well from the sick, and moved all to the pine woods and changed their food and water, after which he lost not a single case, but came near losing his own life. He was stricken with the disease, and in trying to reach the house of a friend was found on the road-side by a faithful servant. He was refused shelter in the house near which he was found, but was given the use of a skiff. This faithful servant then took him to Dr. L. Lucketts, an old and loved friend, where he was for several days at death's door. Then, during the epidemic of yellow fever in 1853, he sent all his children out of town and filled his house with sick, and was, during the greater part of the time, the only physician up; and the only sleep he got was in his buggy as he was driven from door to door.



His success here in this city during the epidemics of 1867 and 1878, the books of the Board of Health will show, and a search through the records of Trinity parish and the Howard Association will give some idea of the amount of charity practice he did here.

REPORT OF COMMITTEE ON NECROLOGY—LOUISIANA STATE  
MEDICAL SOCIETY.

Dr. John Pintard Davidson, of New Orleans, was born on December 8, 1812, at Pinckneyville, Wilkinson county, Miss., and died March 20, 1890, in his seventy-eighth year. He was the oldest practitioner in New Orleans. He loved the companionship of much younger men and shared in their ardor and enthusiasm, and yet his life was tempered with that conservatism which is acquired only by age and thoughtful observation. He stood between us of this day and the men of the remote past, many of whose names will ever be memorable in the medical archives of Louisiana. His reminiscences of those men and this time he often told, in his own happy, knowing way, to the delight of those who knew him in his social life.

Dr. Davidson inherited the traditions of medicine. His father, a physician, was a surgeon in the United States army and came to New Orleans in 1804.

The subject of this sketch was educated in the east and graduated in medicine at the University of Pennsylvania. Returning to New Orleans in 1832, the year in which the present Charity Hospital buildings were erected, he at once entered the medical service of this institution. He subsequently settled in Rapides parish, and there lived and practiced extensively until the outbreak of the civil war. He then went to the front as captain of the Alexandria Rifles, and having served in the campaigns of Corinth and Shiloh, he was obliged to return to his home, being broken in health and fortune.

Since 1855 Dr. Davidson lived and practised medicine in New Orleans. No medical man of his day was more endeared to the profession and the people of this city.

He was prominent in all the medical societies of this city, having served as president of the New Orleans Medical and Surgical Association, and at the time of his death occupying the presidency of the Orleans Parish Medical Society. He was among the first members of our State society, and honored among its presidents.

He rendered distinguished service in connection with the State Board of Health, by appointment of Governor Wiltz in

1878. He served under commission from the Howard Association in the epidemic of yellow fever at Shreveport, and for many years, up to the time of his death, he was a member of the Commission of Experts appointed by the State Board of Health. He was among the foremost in our ranks, and none were more beloved and respected.

In his death we mourn the loss of a member whose face was always familiar at the meetings of the society, whose earnest, honest ways always carried conviction with them, and whose examples as a man, as a physician, also as a benefactor, actuated by feelings of broadest charity and good will toward men, deserves our emulation at all times.

# N. O. Medical and Surgical Journal,

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Articles from physicians are respectfully solicited. All articles, news and exchanges, and books for review, should be sent to the EDITOR, NEW ORLEANS MEDICAL AND SURGICAL JOURNAL. Business communications should be addressed to the BUSINESS MANAGER, NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

EDITED AND PUBLISHED BY

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DR. R. MATAS.

DR. JOHN DELL'ORTO.

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## Editorial Articles.

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### ANNOUNCEMENT.

The NEW ORLEANS PUBLISHING COMPANY has transferred the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL to DR. AUGUSTUS McSHANE, who assumes full charge of the Editorial Department.

The present number is the first under the new arrangement.

Many illustrious names have become identified with the JOURNAL. Since its foundation in 1844, the editorial department has, at various times, been controlled by men who will always live in the annals of American medicine. Those who can not boast a world-wide fame, can, in an humble way, make themselves serviceable to the world in general, and the medical world in particular. There is always room in this work-a-day world for such as are willing to contribute their mite to the general mass of toil, and on this basis the editor hopes to claim a right to exist.

\* \* \*

Every journal should have a reason to exist; it should have some definite, tangible object to fulfil. The tasks to which the JOURNAL shall address itself shall be to spread



general medical intelligence among its readers and, chiefly, to cultivate closer relations among the members of the profession in Louisiana. It hopes that it will thus aid in building up a strong, compact State medical organization that will embrace all of the intelligent and progressive medical men of Louisiana.

For the purpose of carrying out this idea of consolidating the profession of the State, the JOURNAL will publish each month, under the head of "State News," such items as may be of personal or general interest to Louisiana physicians. We hope to publish regularly proceedings of the local societies of the State, and to give abstracts of the official proceedings of our State medical institutions, a list of which is given in the present number of the JOURNAL. The vast amount of clinical material contained in these institutions does not find representation in current medical literature commensurate with its importance. The JOURNAL will strive to be the mouthpiece of physicians of Louisiana, and to place before the medical world the labors and achievements of our medical men.

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The present number begins a new volume. It opens with the report of nineteen cases of infusion of salt-solution, which would have been allowed to pass into oblivion had it not been for our indefatigable co-laborer. Much material is thus allowed to pass unnoticed simply for lack of a recorder. This is not as it should be. It deprives the individual operators of their due meed of fame and causes the profession as a whole to remain in the background. The JOURNAL stands ready to do its full share in the work of giving Louisiana physicians proper representation. But it can not do everything; it must have the coöperation of the profession.

The world moves, and the JOURNAL proposes to move with it. The time has come when it is deemed advisable to reduce the price of the JOURNAL. The price has accordingly been reduced from \$3 to \$2 per annum.

MRS. RICHARDSON'S GIFT TO THE MEDICAL DEPARTMENT OF  
THE UNIVERSITY.

It is with great pleasure that we chronicle the donation of \$100,000 by Mrs. Dr. T. G. Richardson to the medical department of the Tulane University of Louisiana.

Events of that character are, unfortunately, too rare in our community. Since Mr. Paul Tulane gave the princely sum of \$1,250,000 to the University of Louisiana, no considerable donations have been made, save those of Mrs. Richardson and Mrs. Newcombe.

The motives actuating the generous donatrix in selecting the medical department for the bestowal of her gift are not difficult to find. For thirty-seven years her eminent husband was connected with the medical department. He was professor of anatomy from 1852 to 1872; Professor of Surgery from 1872 to 1879; and Dean of the Faculty from 1865 to 1885. Ill health compelled him, in 1889, to sever official connection with the medical department; but the cessation of official relations did not put an end to the lively interest which he always had for the college. Sharing in this warm feeling, Mrs. Richardson freely gave of her store in order to advance the interests of the school with which her husband's name has become inseparably connected.

The donation will be devoted exclusively to the erection of new college buildings.

The Educational Board of Tulane University has purchased, for \$35,000, three-quarters of the square of ground bounded by Canal, Robertson, Customhouse and Villere streets. With ample space and funds, we confidently look forward to a building that will be an ornament to New Orleans.

The important work of drawing a suitable plan for a medical college has been intrusted to Dr. Edmond Souchon, the present Professor of Anatomy. The doctor is already acquainted with the construction of the prominent medical colleges of this country, and that of Paris, where he spent several years in study. In order, however, thoroughly to familiarize himself with all of the commendable features in the construction of a good medical college, Dr. Souchon will visit the large cities of the Union, and examine carefully the details of the

model colleges. In his trip he will visit Baltimore, New York, Philadelphia, Boston and other large cities. He will be accompanied by an architect, who will carry out and execute the ideas of Dr. Souchon. This "voyage of exploration" will consume a good deal of time, but it is expected that work will begin on the new building by December 1, 1891, and will be ready to receive students by October 1, 1892.

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We can not repress a few reflections suggested by the site selected. In the large cotton yard, where the new buildings will be erected, there was a broad shed, surmounted by a belfry, which was dismantled some years ago. For a number of years, in recent times, that deep-toned bell rung out the fire alarms, and during the late "unpleasantness" between the North and South, it peeled forth a warning whenever a Yankee gunboat was descried coming up the river. That function ceased in April, 1863, when General B. F. Butler paid a visit to New Orleans preceded by Admiral Porter. The numerous visitors that General Butler brought with him were quartered in various parts of the city, and one of the places selected was Wood's Cotton Yard. The writer was wearing the garments of infancy when Butler first enjoyed the hospitality of New Orleans; the General was warmly received, but many people thought he stayed too long. At the close of the war, the writer had not grown much older, but he was old enough to remember the Federal soldiers taking their supper on the broad, neutral ground on Claiborne street and in Wood's Cotton Yard.

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*Tempora Mutantur.* On the ground where the rattle of invaders' bayonets was heard nearly thirty years ago, will soon be heard the eloquent voices of teachers instructing ardent youths how to save human life and not destroy it. In olden times the prophet urged the warriors to turn their swords into ploughshares, and their spears into pruning-hooks. Now, the fancy lightly turns to swords made into amputating knives, and muskets into bistouries; and where once the chilling clink of bayonets was heard, nothing more discordant than the cutting of the dissecting knife shall disturb the timid ear.



## HOSPITAL FOR WOMEN AND CHILDREN.

It gives us great pleasure to note the now assured success of the hospital for women and children, which is advertised in the JOURNAL. It was formally opened to the public last January. We are glad to say it is everything it is claimed to be. It is spoken of most favorably by all who have in any way been connected with it, especially by those physicians who have had occasion to send patients to this institution.

All are loud in their praise of the nursing, which is most thorough.

Every care and attention is given the patients. It is strictly private, and only women and children are admitted. The hospital is well equipped and little remains to be done to put the institution on a footing with others of its kind in the south. It is certainly a great boon to physicians and patients. The former can feel assured that their interest will be looked to in every particular, and patients can feel that they will be as private and as comfortable as in their own house, with a *trained nurse* to care for them.

## THE INTERNATIONAL AMERICAN MEDICAL CONGRESS.

For many years efforts have been made to bring about closer relations with the countries to the south of us. It is gratifying to note that the medical profession is doing its share toward cementing the friendship among the American republics. A long step in advance has been made, as will be seen from the annexed circular from the Secretary of the American Medical Association. We are glad that the initiation has been taken by North American physicians, and congratulate the Committee and Louisiana upon the selection made to represent our State upon the Committee on Permanent Organization.

## THE INTER-CONTINENTAL AMERICAN MEDICAL CONGRESS.

OFFICE OF THE PERMANENT SECRETARY  
OF THE AMERICAN MEDICAL ASSOCIATION, }  
PHILADELPHIA, June 4, 1891. }

*To the Medical Profession of the Western Hemisphere:* At the meeting of the American Medical Association, held at

Washington, May 5, 1891, Dr. Charles A. L. Reed, of Cincinnati, introduced the following:

*Resolved*, That the American Medical Association hereby extends a cordial invitation to the medical profession of the Western Hemisphere, to assemble in the United States in an Inter-Continental American Medical Congress.

*Resolved*, That the Committee on Nominations be and is hereby instructed to nominate one member for each State and Territory, and one each from the army, navy and Marine Hospital service, who shall constitute a committee, which is hereby instructed to effect a permanent organization of the proposed Inter-Continental American Medical Congress, and to determine the time and place at which the same shall be held.

The resolutions were seconded by Dr. Wm. H. Pancoast and others, and unanimously adopted.

Pursuant to the foregoing the following committee was nominated and elected:

Ala., W. H. Sanders, M. D.; Ariz., Henry A. Hughes, M. D.; Ark., Ed. Bentley, M. D.; Cal., W. R. Cluness, M. D.; Colo., Wm. A. Campbell, M. D.; Conn., C. A. Lindsey, M. D.; Del., C. H. Richards, M. D.; D. C., D. W. Prentiss, M. D.; Fla., C. R. Oglesby, M. D.; Ga., J. McFadden Gasten, M. D.; Idaho, Geo. P. Haley, M. D.; Ill., N. S. Davis, M. D.; Ind., A. M. Owen, M. D.; Iowa, B. H. Crilley, M. D.; Kan., J. E. Minney, M. D.; Ky., J. N. McCormack, M. D.; La., Stanford E. Chaille, M. D.; Maine, Hampton E. Hill, M. D.; Md., Geo. H. Kohe, M. D.; Mass., Augustus P. Clarke, M. D.; Mich., C. Henri Leonard, M. D.; Minn., P. H. Millard, M. D.; Miss., W. T. Kendall, M. D.; Mo., I. N. Love, M. D.; Mont., Thos. J. Murray, M. D.; Neb., R. C. Moore, M. D.; Nev., P. J. Aitken, M. D.; N. H., Irving A. Watson, M. D.; N. J., E. J. Marsh, M. D.; New Mex., C. E. Winslow, M. D.; N. Y., John Cronyn, M. D.; N. C., H. Longstreet Taylor, M. D.; N. D., E. M. Barrow, M. D.; Ohio, Charles A. L. Reed, M. D.; Oregon, Wm. Boys, M. D.; Pa., Wm. Pepper, M. D.; R. I., Geo. L. Collins, M. D.; S. C., R. A. Kinloch, M. D.; S. D., J. W. Freeman, M. D.; Tenn., J. R. Buist, M. D.; Tex., J. W. Carhart, M. D.; Utah, F. S. Bascom, M. D.; Vt., H. H. Holton, M. D.; Va., J. S. Wellford, M. D.; Wash., J. H. Morgan, M. D.; W. Va., I. H. Brownfield, M. D.; Wis., J. T. Reeve, M. D.; Wyo., J. H. Fintrock, M. D.; U. S. A., —; U. S. N., A. L. Gihon, M. D.; U. S. M. H. S., J. B. Hamilton, M. D.,  
WM. T. BRIGGS, *President*.

WILLIAM B. ATKINSON, *Permanent Secretary*.

THE INTER-CONTINENTAL AMERICAN MEDICAL CONGRESS, }  
OFFICE CHAIRMAN OF COM. ON PERMANENT ORGANIZATION, }  
CINCINNATI, June 6, 1891. }

The committee appointed by the American Medical Association to effect a permanent organization of the Inter-Continental Medical Congress, met at "The Arlington," Washington, May 7, 1891. The following officers were elected: Charles A. L. Reed, M. D., Cincinnati, O., chairman; J. W. Carhart, M. D., Lampasas, Tex., secretary; I. N. Love, M. D., St. Louis, Mo., treasurer.

On motion, the officers were appointed a special committee to draft a constitution, and report the same at an adjourned meeting of the general committee, to be held at St. Louis, Mo., Wednesday, October 14, 1891, when the time and place of meeting of the Congress will be decided, and permanent officers be elected.

CHARLES A. L. REED, M. D., *Chairman*.

J. W. CARHART, M. D., *Secretary*.

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## State News.

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[Communications from Physicians of Louisiana are solicited for this Department. News of personal interest is especially desired.]

The following lists comprise the largest and most prominent medical institutions of the State :

Alexandria Charity Hospital, Alexandria, La. ; capacity, 40.

Charity Hospital, New Orleans; capacity, 700. Dr. A. B. Miles, house surgeon.

Eye, Ear, Nose and Throat Hospital, New Orleans: Out-cylinic. Drs. A. W. de Roaldes and S. D. Kennedy.

Hotel Dieu, New Orleans; capacity, 150. Dr. David Jamison, physician in charge.

Louisiana Retreat for the Insane, New Orleans. Dr. E. T. Shepard, physician. In charge of the Sisters of Charity.

State Lunatic Asylum, Jackson, La. Dr. L. G. Perkins, physician in charge.

Shreveport Charity Hospital; capacity, 60.

Small Pox Infirmary, New Orleans: capacity, 250. Dr. Geo. Huhner, physician in charge.

Touro Infirmary, New Orleans; capacity, 150. Dr. F. Loeber, physician in charge.

U. S. Gulf Quarantine Station, Chandeleur Islands; capacity, 164. Dr. Hy. R. Carter, physician in charge.

U. S. Marine Hospital, New Orleans; capacity, 60. Dr. J. B. Gassoway, surgeon in charge.

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Dr. A. W. de Roaldes, of New Orleans, left for Europe on the 20th ult. On his way he will visit Detroit, Mich., to examine Drs. Shurley and Gibbes' method of treating con-



sumption. He will also visit all the prominent ear and throat clinics of Europe, and will return about October 1, 1891. The doctor will send the JOURNAL some correspondence, giving his impressions of the famous clinics. The JOURNAL wishes the doctor a safe and pleasant trip.

Dr. H. W. Blanc, of New Orleans, has decided to leave the city of his birth to settle in Sewanee, Tenn. The doctor, will, however, continue to favor the JOURNAL with valuable contributions on dermatology and hygiene, and will give reviews of pediatric notes. While the JOURNAL congratulates Sewanee on its accession, it can not help deploring the loss suffered by New Orleans.

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## Abstracts, Extracts and Annotations.

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### SURGERY.

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#### VENTRAL HERNIA—RUPTURE OF COVERINGS—ESCAPE OF INTESTINES AND THEIR EXPOSURE FOR EIGHTEEN HOURS—RECOVERY.

By JAMES J. MCKONE, M. D., Surgeon to St. Joseph's Hospital, Tacoma, Washington.

Mrs. J., aged 49 years, mother of one child 16 years of age, was twelve years ago treated for what her physician called an abscess of the abdominal wall. She was confined to bed for ten months. When she got around again she, for the first time, noticed a hernia. With the exception of weakness from this she suffered no more until the current year, when she noticed the skin over the "tumor" becoming black; she consulted a physician, who told her it was gangrene of the skin, and who applied treatment.

February 10th, about a month later, she fell from a stoop, and the gangrenous tissue gave way for an extent of four and one-half inches, from just below the umbilicus in a direction downward and outward toward the centre of Poupart's ligament on the right side. Through this wound thirty-four inches of the small intestines escaped. The patient walked into the house without assistance and went to bed. Her husband covered the gut with a towel and sent for Dr. Norgren, a Norwegian physician. The latter not being at home, and the husband being unable to speak a word of English, he waited

for Dr. Norgren till the following morning, the intestines meanwhile lying on the abdomen covered by the towel.

I was called to the case by Dr. Norgren at 3 P. M. The accident had happened at 9 P. M. of the previous evening, making the time during which the intestines had been exposed eighteen hours. The towel was found adherent to the intestines; after it was carefully removed by irrigation with hot bichloride solution, the exposed coils of intestines were found matted together by recent adhesions, which were easily broken.

The patient's temperature was good; the pulse 90 and full; the temperature 100 deg. Ether was now administered, and examination showed that the abdomen was traversed by thick bands of adhesions, most of which ran between the two widely separated portions of the abdominal fascia. These bands were tied and separated, the abdominal cavity thoroughly irrigated with hot water and the intestines returned. On account of the large amount of gas it was necessary to puncture the gut with a small trocar before reduction could be accomplished. The cavity of the abdomen was again thoroughly irrigated, and the wound closed by a continuous silk suture; after cutting away the gangrenous tissue, which consisted of a strip one inch wide in the whole length of the wound, a glass drainage-tube was inserted in Douglas' pouch and brought out at the lower angle of the wound.

It was impossible to perform an operation for the radical cure of the hernia, as the intestines above and to the right side of the rent were firmly adherent to the inner surface of the integument by adhesions which could not be separated, this integument constituting the sole covering of the intestines, the peristaltic action of which was distinctly visible through the thin tissue. The dressing consisted of bichloride gauze, covered by absorbent cotton soaked in glycerine, the whole being retained by a wide binder.

The patient recovered quickly from the anæsthetic, which was administered by Dr. A. E. Burns, of Brooklyn, and had an almost uninterrupted recovery. The temperature rose to 103 degrees on the fifth day, but promptly subsided after free purgation with sulphate of magnesium. The glass tube, which had discharged quite freely, was removed on the third day, when a rubber one was substituted. After the first day there was scarcely any pain; the patient's appetite returned immediately; she was fed on raw eggs and milk for ten days, when an ordinary diet was allowed. The dressing was removed on the eighth day, and primary union found to have taken place, except in the track of the drainage-tube, in

which granulation subsequently took place. The patient is now up and around, and able to attend to her household duties.

This is a most remarkable case. Here is a woman, with most unhygienic surroundings—the shanty in which she lived consisting of one room, which served as bedroom, kitchen and cellar—lying for eighteen hours with thirty-four inches of her intestines outside the abdomen, and peritonitis well advanced, subjected to the additional shock of an anæsthetic and manipulation, who goes on to recovery with scarcely a bad symptom. That she did not have a fatal traumatic peritonitis is probably due to the fact that continued irritation of the peritoneum for years had made it tolerant of abuse. This may also account for the absence of shock. As to sepsis, I have nothing to say.—*Med. News.*

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#### PUNCTURED FRACTURE OF THE SKULL IN WHICH THE SUPERIOR LONGITUDINAL SINUS WAS WOUNDED.

By WILLIAM J. TAYLOR, Surgeon to St. Agnes Hospital.

For the history of this case I am indebted to Dr. John B. Maloney, resident physician.

W. R. J., aged 35 years, was admitted to the surgical wards of St. Agnes Hospital, about midnight of June 25, 1890, suffering from a punctured fracture of the vertex of the skull. He was brought to the hospital in a patrol wagon, but walked into the wards. Except for a little anxiety and a disposition to quarrel on not being immediately shown to bed, it could not have been known that anything was wrong.

The man could give no account of the injury, but the police officer stated that he had been struck on the head by a pick at 1 o'clock in the morning, just half an hour before he was seen by me. He became delirious, spoke of his friends, and did not recognize those about him. At half-past 1 o'clock he was placed under the influence of ether and the wound examined.

Two inches from the glabella, and about one-half inch to the right of the median line, was a small wound of the scalp, having an appearance as though made by a pick or other pointed instrument. The skull beneath was punctured, and the bone broken into small fragments, which were driven down into the brain-substance. The opening was just large enough to permit the insertion of the finger. The wound was enlarged with a knife, and the scalp turned back. The edges of the skull were cut away by



a rongeur forceps, and the depressed pieces of bone removed. It was then seen that the wall of the superior longitudinal sinus had been wounded by a fragment of bone. The hemorrhage was profuse. Pressure with forceps controlled the bleeding, until a larger opening, two and a quarter inches long by two inches wide, and extending one-half inch to the left of the median line, was made in the bone, thoroughly exposing the sinus, and including the whole area of fracture. The dura was torn and the brain itself lacerated. Blood flowed freely from the small tear in the wall of the sinus, which was about one-quarter of an inch long. Packing would not control the hemorrhage. The patient having already lost a large quantity of blood, and as the imperfect light made it difficult to see, the opening in the sinus was included in the grasp of a pair of hæmostatic forceps, and the hemorrhage completely controlled; the forceps were allowed to remain. The dura was freely opened, and the brain examined with the finger. The wound was then carefully disinfected; so much of the wound in the dura as was possible was brought together with catgut sutures, and the whole was packed with iodoform gauze.

The patient reacted nicely from the operation. At the end of seventy-two hours the hæmostatic forceps were removed from the wound in the sinus; there was no hemorrhage that was not easily controlled by a packing of iodoform gauze gently applied. On the third day there were symptoms of intense cerebral irritation, with delirium and restlessness, so that it became necessary to strap the man in bed and give morphine and bromides. For some days he passed both urine and fæces in bed, and was extremely weak. He gradually regained strength, and his mind became clear again. The wound healed by granulation. The patient was discharged from the hospital on August 29 entirely well, and returned to his work.—*Medical News*.

## MEDICINE.

### ETIOLOGY OF BRIGHT'S DISEASE.

J. Mannaberg (*Zeuschrift f. klin. Medicin*, 1890) does not regard the commonly accepted causes of Bright's disease as entirely satisfactory or complete. He accepts the mechanical theory of catching cold as the cause of the malady; the blood being driven to the internal organs causing hyperemia in

the vessels of the kidneys, the first step to the development of nephritis. Lassar observed that on plunging well-heated rabbits into ice water he could produce interstitial inflammation in the kidneys, although this same process was noticed in the heart, liver and lungs. Dyscrasia, superalbuminosis and sub-albuminosis of the blood, and vaso-motor disturbances are also considered in their etiological aspect. Among other theories are those founded upon the observations which appear to show the infectious character of many cases of acute Bright's disease.

Studying first the nephritis occurring as a complication in other diseases, Mannaberg finds, in a large number of cases, sufficient data to lead him to suspect the bacterial origin of the renal trouble. He believes that chronic diseases, such as tuberculosis, chronic suppurative processes, syphilitic ulcers, etc., can produce nephritis by the passage of their bacteria through the kidneys. He finds, however, that acute diseases are more active in producing infectious nephritis. The observations on this subject are not fully established as yet. This is the extent of our present data. The nephritis occurring in scarlet fever is due possibly to a toxine; in diphtheria to a ferment produced by the diphtheritic bacillus; in erysipelas to the streptococci Fehleisen; in pneumonia to the diplococci; in typhoid fever to the typhoid bacillus; in recurrent fever to the spirillum or its toxine. The bacteria of measles, rheumatism, typhus fever, yellow fever, etc., have not been traced in regard to their action on the kidneys. Taking up the subject of acute primary bacteritic Bright's disease, Bamberger's observations, made thirty years ago, were the first to call attention to the possibility of the cause; and his observations, though faulty and obscure, have been confirmed and completed by recent observers.

Mannaberg obtained from the urine of eleven patients streptococci of characteristic appearance and growth which, on cultivation and inoculation in healthy animals, immediately set up acute nephritis. Precautions were taken, of course, to exclude the presence of bacteria due to other causes. The *post mortem* examination of animals so treated to show the presence of any of these bacteria in the kidneys, hence the author believes that the simple elimination of morbid germs is sufficient to alter renal epithelium and produce albuminuria, at least in animals.

In the résumé of the subject he presents the following conclusions: (1) In eleven cases of acute Bright's disease numerous streptococci were found in the urine; they disappeared from it at the end of the disease. (2) This streptococci has

never been seen in the urine of patients suffering from other diseases, or in healthy people. (3) This streptococci can be cultivated; in this point it differs from the streptococcus previously known. (4) Injection of this streptococcus in dogs and rabbits produces intense nephritis; in rabbits it also produces endocarditis. (5) The cocci are not increased in the kidney; they influence the kidney in their passing. (6) These streptococci produce Bright's disease in the cases observed. (7) These cases of Bright's disease in which streptococci are found have a rapid and favorable course.—*University Medical Magazine*.

#### RULES FOR THE MANAGEMENT OF INFANTS DURING THE HOT SEASON.\*

By WILLIAM GOODELL, M. D., of Philadelphia.

*Rule 1.*—Bathe the child once a day in tepid water. If it is feeble, sponge it all over twice a day with tepid water, or with tepid water and vinegar. The health of a child depends much upon its cleanliness.

*Rule 2.*—Avoid all tight bandaging. Make the clothing light and cool, and so loose that the child may have free play for its limbs. At night undress it, sponge it and put on a slip. In the morning remove the slip and dress the child in clean clothes. If this can not be afforded, thoroughly air the day-clothing by hanging it up during the night. Use clean diapers, and change them often. Never dry a soiled one in the nursery or in the sitting-room and never use one for a second time without first washing it.

*Rule 3.*—The child should sleep by itself in a cot or cradle. It should be put to bed at regular hours, and be early taught to go to sleep without being nursed in the arms. Without the advice of a physician, never give it any *spirits, cordials, carminatives, soothing syrups or sleeping drops*. *Thousands of children die every year from the use of these poisons*. If the child frets and does not sleep, it is either hungry or ill. If ill, it needs a physician. Never quiet it by candy or cake; they are the common causes of diarrhœa and of other troubles.

*Rule 4.*—Give the child plenty of fresh air. In the cool of the morning and evening, send it out to the shady sides of broad streets, to the public squares or to the park. Make frequent excursions on the rivers. Whenever it seems to suffer

\*At a meeting of the Obstetrical Society of Philadelphia, held April 3, 1873, the undersigned committee was appointed "To consider the Causes and the Prevention of Infant Mortality during the Summer Months." The following rules, drawn up by this committee, were revised and adopted by the society at a meeting held May 1, 1873, and ordered to be published.—Dr. William Goodell, chairman; Dr. J. Forsyth Meigs, Dr. John L. Ludlow, Dr. Albert H. Smith, Dr. John S. Parry, Dr. William F. Jenks.



from the heat, let it drink freely of ice water. Keep it out of the room in which washing or cooking is going on. It is excessive heat that destroys the lives of young infants.

*Rule 5.*—Keep your house sweet and clean, cool and well aired. In very hot weather let the windows be open day and night. Do your cooking in the yard, in a shed, in the garret, or in an upper room. Whitewash the walls every spring, and see that the cellar is clear of all rubbish. Let no slop collect to poison the air. Correct all foul smells by pouring carbolic acid or quick-lime into the sinks and privies. The former article can be got from the nearest druggist, who will give the needful directions for its use. Make every effort yourself, and urge your neighbors to keep the gutters of your street or court clean.

*Rule 6.*—*Breast-milk is the only proper food for infants.* If the supply is ample and the child thrives on it, no other kind of food should be given—while the hot weather lasts. If the mother has not enough, she must not wean the child, but give it, besides the breast, goat's or cow's milk, as prepared under Rule 8. Nurse the child once in two or three hours during the day, and as seldom as possible during the night. Always remove the child from the breast as soon as it has fallen asleep. Avoid giving the breast when you are over-fatigued or overheated.

*Rule 7.*—If, unfortunately, the child must be brought up by hand, it should be fed on a milk diet alone, and that warm milk out of a nursing bottle, as directed under Rule 8. Goat's milk is the best, and next to it, cow's milk. If the child thrives on this diet, *no other kind of food whatever should be given while the hot weather lasts.* At all seasons of the year, but especially in summer, there is no safe substitute for milk to an infant that has not cut its front teeth. *Sago, arrow-root, potatoes, corn-flour, crackers, bread, every palatable food, and every article of diet containing starch, can not and must not be depended on as food for very young infants.* Creeping or walking children must not be allowed to pick up unwholesome food.

*Rule 8.*—Each bottleful of milk should be sweetened by a small lump of loaf-sugar, or by half a teaspoonful of crushed sugar. If the milk is known to be pure, it may have one-fourth part of hot water added to it: but if it is not known to be pure, no water need be added. When the heat of the weather is great, the milk may be given quite cold. Be sure that the milk is unskimmed; have it as fresh as possible, and brought very early in the morning. Before using the pans into which it is to be poured, always scald them with boiling suds. In

very hot weather, boil the milk as soon as it comes, and at once put away the vessels holding it in the coolest place in the house—upon ice if it can be afforded, or down a well. Milk carelessly allowed to stand in a warm room soon spoils and becomes unfit for food.

*Rule 9.*—If the milk should disagree, a tablespoonful of lime-water may be added to each bottleful. Whenever pure milk cannot be got, try the condensed milk, which often answers admirably. It is sold by all the leading druggists and grocers, and may be prepared by adding, without sugar, one teaspoonful or more, according to the age of the child, to six teaspoonfuls of boiling water. Should this disagree, a teaspoonful of arrow-root, of sago, or of corn-starch to the pint of milk may be cautiously tried. If milk in any shape cannot be digested, try for a few days, pure cream diluted with three-fourths or four-fifths of water, returning to the milk as soon as possible.

*Rule 10.*—The nursing-bottle must be kept perfectly clean; otherwise the milk will turn sour, and the child will be made ill. After each meal, it should be emptied, rinsed out, taken apart, and the tube, cork, nipple and bottle be placed in clean water, or in water to which a little soda has been added. It is a good plan to have two nursing-bottles, and to use them by turns.

*Rule 11.*—Do not wean a child just before or during the hot weather; nor, as a rule, until after its second summer. If suckling disagrees with the mother, she must not wean the child, but feed it in part, out of nursing-bottle, on such food as has been directed. However small the supply of breast-milk, provided that it agrees with the child, the mother should carefully keep it up against sickness; it alone will often save the life of a child when everything else fails. When the child is over six months' old, the mother may save her strength by giving it one or two meals a day of stale bread and milk, which should be pressed through a sieve and put into a nursing-bottle. When from eight months to a year old, it may have also one meal a day of the yolk of a fresh and rare-boiled egg, or one of beef or mutton broth into which stale bread has been crumbed. When older than this, it can have a little meat finely minced; but even then milk should be its principal food, and not such food as grown-up people eat.

#### BRIEF RULES FOR CASES OF EMERGENCY.

*Rule 1.*—If the child is suddenly attacked with vomiting, purging and prostration, send for a doctor at once. In the meantime, put the child for a few minutes in a hot bath, carefully wipe it dry with a warm towel, and wrap it in warm

blankets. If its hands and feet are cold, bottles filled with hot water and wrapped in flannel should be laid against them.

*Rule 2.*—A mush poultice, or one made of flaxseed meal, to which one-quarter part of mustard flour has been added, or flannels wrung out of hot vinegar and water, should be placed over the belly.

*Rule 3.*—Five drops of brandy in a teaspoonful of water may be given every ten or fifteen minutes; but if the vomiting persists, give the brandy in equal parts of milk and lime-water.

*Rule 4.*—If the diarrhœa has just begun, or if it is caused by improper food, a teaspoonful of castor oil or of the spiced syrup of rhubarb should be given.

*Rule 5.*—If the child has been fed partly on the breast and partly on other food, the mother's milk alone must now be used. If the child has been weaned, then it should have pure milk with lime-water, or weak beef-tea, or chicken-water.

*Rule 6.*—The child should be allowed to drink cold water freely.

*Rule 7.*—The soiled diapers or the discharges should be at once removed from the room, but saved for the physician to examine at his visit.

FOR THE CONVENIENCE OF MOTHERS THE FOLLOWING RECIPES  
FOR SPECIAL FORMS OF DIET ARE GIVEN.

*Boiled Flour or Flour Ball.*—Take one quart of good flour; tie it up in a putting-bag so tightly as to get a firm, solid mass; put it into a pot of boiling water early in the morning, and let it boil until bedtime. Then take it out and let it dry. In the morning, peel off from the surface and throw away the thin rind of dough, and with a nutmeg-grater grate down the hard, dry mass into a powder. Of this from one to three teaspoonfuls may be used, by first rubbing it into a paste with a little milk, then adding to it about a pint of milk, and, finally, by bringing the whole to just the boiling-point. It must be given through a nursing-bottle.

An excellent food for children who are costive in their bowels may be made by using bran-meal or unbolted flour instead of the white flour, preparing it as above directed.

*Rice Water.*—Wash four tablespoonfuls of rice; put it into two quarts of water, which boil down to one quart, and then add sugar and a little nutmeg. This makes a pleasant drink.

A half pint or a pint of milk added to this, just before



taking it from the fire, and allowed to come to a boil, gives a nourishing food suitable for cases of diarrhœa.

Sago, tapioca, barley and cracked corn can be prepared in the same manner.

*Beef Tea.*—Take one pound of juicy, lean beef—say a piece off the shoulder or the round—and mince it up with a sharp knife on a board or a mincing-block. Then put it with its juice into an *earthen* vessel containing a pint of tepid water, and let it stand for two hours. Strain off the liquid through a clean cloth, squeezing well the meat, and add a little salt. Place the whole of the juice thus obtained over the fire, but remove it as soon as it has become browned. Never let it boil; otherwise most of the nutritious matter of the beef will be thrown down as a sediment. Prepared in this way the whole nourishment of the beef is retained in the tea, making a pleasant and palatable food. A little pepper or allspice may be added if preferred.

*Mutton Tea*—May be prepared in the same way. It makes an agreeable change when the patient has become tired of beef tea.

*Raw Beef for Children.*—Take half a pound of juicy beef, free from any fat; mince it up very finely; then rub it up into a smooth pulp either in a mortar or with an ordinary potato masher. Spread a little out upon a plate and sprinkle over it some salt, or some sugar if the child prefers it. Give it with a teaspoon or upon a buttered slice of stale bread. It makes an excellent food for children with dysentery.—*Annals of Hygiene.*

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### ABORTING PNEUMONIA.

By OLIVER J. ROSKOTEN, M. D., Peoria, Ill.

In view of the dreadful mortality from pneumonia at the present time, any suggestion bearing on treatment must be of interest to the medical practitioner. Limited though my experience be, I give it for the benefit of others in the hope that a trial by unbiased men may confirm the observations which I have made in a few cases.

In company with others I find that in acute lobar pneumonia (to which variety alone I now refer), after exudation and consolidation have taken place, I am nearly, if not quite, powerless to modify the course of the disease under any treatment now in vogue. This deplorable fact was very forcibly impressed on me some time ago by the loss from heart failure of several patients in quick succession. After prolonged consideration I concluded that the period most promising of suc-

cess in medication must be that preceding the exudation, *i. e.*, the stage of engorgement, that in which, beyond excessive vascularity and perhaps some moderate effusion, no great anatomical change has yet disturbed the recuperative powers of the lung threatened.

Can pneumonia be diagnosticated thus early?

I find that with reasonable certainty it can, at least if a severe chill and other symptoms to be named are accepted as sufficient. The chill comes on suddenly in a person previously of good health, is rapidly succeeded by stitch pains in the side (or at some one of the less frequent points, *e. g.*, the lateral part of the epigastric region), by short, suppressed, locally painful, dry cough, somewhat accelerated, superficial respiration, elevated temperature and pulse rate, with just noticeable dullness on percussion, respiratory murmur only tinged, as it were, with a tubular element, and a larger or smaller number of the ominous fine, crackling, crepitant râles audible on deep inspiration over the affected, but as yet limited, area at the base. The respiratory murmur here has lost its soft rustling character; is probably weakened by instinctive favoring of the opposite sound side, and there is exaggerated.

No one can deny the close relationship between the skin and the respiratory organs. Sudden suppression of cutaneous exhalation ordinarily is quickly followed by a catarrhal state of some portion of the air passages, but the noxious influence developed through disturbance of the function of the skin may skip the less important and generally less resisting mucous membranes, and precipitate an inflammation in the deeper parts. Why this should occur we can only surmise. I take it as probable that the respiratory centre does not alone regulate the proper working of the main respiratory mechanism, but that of the subsidiary organs, especially the skin, as well. Its connections with the vaso-motor centres and nerves must hence be very complex, and one can understand how it must be exposed to the frequent disturbances, I may say strains, on its integrity by abnormal influences reaching it from all the organs over which it presides.

I, therefore, regard acute nasal, laryngeal, bronchial catarrhs, and even acute croupous pneumonia, as so many manifestations of disturbed equilibrium between the respiratory and the vaso-motor centres, the localization of the affection depending on the intensity and other characters of the primary irritation, as well as upon the condition of the centre itself.

I determined to make some impression on this centre, be it good or bad, in the next case of pneumonia which should chance to fall into my hands, intending thus to gain an experi-

ence which would guide me to a rational therapeutics in other cases. I decided upon jaborandi, and soon had an opportunity to test it.

A fairly strong cattle feeder in one of our distilleries suffered a prolonged wetting of the feet at his occupation, and was well soaked in a rain storm on his way home. He was that evening seized with a violent chill and all the symptoms enumerated above. A few hours later I made the diagnosis of acute lobar pneumonia, located at the right base. I placed him on the following inelegant mixture:

Rx. Extr. fl. jaborandi.....	3	ijj.
Liq. aminon. acet.....		j.
Tinct. aromat.....		ij.
Syrupi aromat.....		i.
Aquæ dest.....	q. s. ut ft.	iv.

M. Sig.: Tablespoonful every hour until thorough effect, then half doses every two hours.

I also ordered a hot pediluvium, and some mild counter-irritant. After two doses a most profuse diaphoresis ensued, which was prolonged by lessened doses of the medicine until I saw him next morning. The temperature, previously 103 deg. Fahr., was now found to be 98 deg. Fahr.; pulse, 80; some stitch pains left, but general condition vastly improved. The local signs had not progressed. Little or no salivation. As there was no occasion for any change in medicine, the patient was directed to continue the remedy at longer intervals. My astonishment can be imagined when at the third visit, next day, I found the bird flown, himself and family to this day doubting my diagnostic acumen!

I have practised this method in four cases since then, with three signal successes, while the fourth, a failure, was probably an instance of mistaken diagnosis; anyway, pleurisy was recognized a few days later, though pneumonia may have existed and been aborted.

I have confined this treatment to the earliest stage of the variety known as acute lobar pneumonia, and can not speak of experience in any other, but during last year's run of la grippe I have freely used the remedy, with the result that I have not met with a single instance of pneumonia in the course of the epidemic, although the number of cases treated was quite large.

The theoretical objection to jaborandi or pilocarpine, on the ground of its being a depressant to the heart, I have met, by the addition of aromatic stimulants, and in one or two cases, of digitalis. I aimed to have each dose absorbed in a little less than one hour, delaying absorption (if the stomach was empty) by having it diluted with a small quantity of hot water or tea, in order to avoid a too suddenly violent effect and attendant



dangers; and for this reason also I have preferred the extract to the active principle. In very weak persons, and in those afflicted with fatty or valvular disease of the heart, the remedy in efficient doses is undoubtedly dangerous.

I have ventured to bring the remedy to the notice of the readers of the *Medical Record* with some diffidence, as the number of cases on which the report rests is too small to convince even myself, but there is enough encouragement in the results observed to warrant a trial on a larger scale by those who enjoy more extended opportunities.—*N. Y. Med. Record*.

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### A STUDY OF ERGOT.

In the Johns Hopkins Laboratory Dr. John C. Hemmeter, of Baltimore, Md., made an elaborate series of experiments, the object of which were:

1. To determine whether the contractions of the uterus by ergot are of centric or peripheral origin.
2. Whether the peristalsis of the intestines is increased or diminished by ergot. If increased, whether this be due to a centric or peripheral action of ergot.
3. Whether the cause of the contraction of the blood vessels in the omentum is central or peripheral.
4. Whether ergot produces a rise or a fall of blood pressure. Whatever change occurs, is it due to an action on the heart and arteries or on the spinal cord.
5. The action of ergot on temperature.

Dr. Hemmeter says: "In no department of experimental therapeutics do we meet with such manifold and contradictory results, or with more widely digressing theories than those concerning the action of ergot. This is especially true in the investigations that have hitherto been made relating to the nature and cause of the contraction of the pregnant and non-pregnant uterus, which is produced by this drug. Up to the present time it has not been established whether the action of ergot in this case is a peripheral or central one: that is, whether ergot acts by innervating the uterus through the spinal cord, or directly on the muscular fibre of the organ.

H. C. Wood admits the uncertainty, but thinks that the drift of present evidence is toward peripheral action.

T. Lauder Brunton intimates that ergot possibly acts like ammonia, producing contraction of the uterus after all nervous connections have been divided, but gives no experimental evidence for deciding the point.

Rosenbach is inclined to accept a direct and local action

of ergot upon the muscular tissue of the uterus, indirectly causing contraction by bringing on acute anemia of the organ.

These contradictory statements may be partly explained by the fact that the uteri of different animals vary greatly with regard to their irritability, and to the manner in which they respond to stimulations by general contractions. A part of the discrepancies in the opinion of the investigators mentioned might be explained by the fact that the quality and efficacy of ergot and of its preparations obtainable in pharmacies vary greatly.

As the watery infusion of fresh ergot (this having been used by former investigators) was found to undergo changes very rapidly, I concluded to resort to the fluid extract of ergot, but found this, as obtained from various sources, very variable, both in physical properties and therapeutic efficacy, some of the specimens having a very offensive odor. In two German preparations of ergotin, and one liquid ergotin prepared in Basle, Switzerland, and specially recommended by the manufacturer for hypodermic use, a very unpleasant foetid odor, reminding of decomposed organic matter, was noticeable, and the last named used hypodermically proved very irritating, causing an abscess in a patient suffering from goiter.

Some of the secondary results in the experiments upon animals were caused by the impurities of the ergot used.

My attention was at last called to a form of liquid ergotin made in Baltimore by Sharp & Dohme, which gave evidences of being a standard preparation, both in clinical and experimental application. I have had some of this ergot in my possession for nearly ten months (since February 3, 1890). It has deposited no sediment, has a fresh, pure odor and is very effective. This ergotin solution, which is probably the most concentrated liquid preparation of ergot that can be obtained, has since become known under the name of *ergotole*, to distinguish it from the numerous and widely-differing preparations sold under the name of ergotin. In my experiments this form of ergot was used, together with two forms of fluid extract of ergot, the officinal containing hydrochloric acid, the other no acid, which, however, were more bulky.

After the injection of 1 c. c. of fluid extract of ergot (about sixteen minims), the capillaries and arterioles in the omentum of a large rabbit could be seen to contract within from five to eight minutes, and the uterus showed peristaltic contractions. On the other hand, 0.25 c. c. (four minims) of the liquid ergot just described produced the same effect on the arterioles in from two to three minutes (rarely five minutes), and the contractions of the uterus were more active and fol-

lowed each other with greater rapidity. The ergot in both cases was diluted with the same quantity of distilled water, and injected into the jugular vein in preference to the hypodermic method, as the absorption of solutions of ergot from beneath the skin in animals is very slow.

I began my experiments by first curarizing the animal (rabbit), and then isolated the uterus from all nervous connections by destroying the spinal cord from the tenth dorsal vertebra to the cauda equina by running a white hot copper wire down the vertebral canal. Experiments on animals thus prepared led to the following conclusions:

Ergot, in producing contractions of the uterus acts primarily and essentially upon the lumbar cord, *i. e.*, its action in causing peristalsis of the uterus is centric, not peripheral.

Ergot, in producing intestinal peristalsis, acts directly on the cord and only reflexly upon the intestines, its action in this case, too, being centric, not peripheral.

Ergot produces constriction of the arterioles and capillaries in the omentum and ear of rabbits and in the frog's web as long as the cord and the vagi are intact. These being destroyed constriction is no longer produced by the drug; its action in this case is centric, not peripheral.

Ergot reduces the number of pulse-beats per minute.

In the isolated frog's heart it reduces the force of the contractions.

It exerts a local poisonous influence on the heart of the batrachian as well as on that of the mammal when injected into the jugular vein.

Its main action, however, is exercised through the influence of the central nervous system.

It raises arterial pressure when injected into the jugular vein of mammals. The rise is preceded by a primary depression due to the local action on the heart.

It is impossible at present to decide whether this local action is due to an influence on the heart muscle or on the cardiac ganglia.

It lowers temperature by reducing the number, force, and tonicity of the cardiac contractions, consequent upon which is loss of tone in the general circulation with its attendant reduction of oxidation processes.

The therapeutic effects of few drugs correspond so closely with their physiological action as do those of ergot.

The theory of its action is based upon the artificial anæmia which it induces in the arterial vessels, so that the histological process of inflammation is impeded.

The power of ergot to reduce temperature, the number



of pulse-beats, the number of respirations, and at the same time maintain increased arterial pressure, makes it a most important agent in the management of the first stage of pneumonia and bronchitis.

We believe that ergot exercises a very decided effect upon the pulmonary vessels.

Transudation has been proved by a very large number of observers, to depend mainly upon the permeability and elastic distensibility of the blood vessels.

If transudation is associated with increased heart's action, we know that ergot reduces the number of heart beats.

If the beginning of pneumonic exudation is associated with hurried breathing, we know that ergot reduces the number of respirations per minute.

If transudation is connected with fever, we know that ergot reduces temperature.

If the fever in inflammatory exudations lowers blood pressure, we know that ergot raises it.

All of these physiological effects directly counteract the main features of the pathological process, and check further transudation, while the lymphatics carry away the exudation that has already occurred.

Upon the power of ergot to constrict the arterioles and to cause arterial and capillary anæmia depends its application in a large number of diseased conditions. It has been successfully used in hæmctypsis, hæmatemesis, epistaxis, hemorrhage from the gums; renal, hemorrhoidal, and vesical hemorrhage; in the bleeding caused by carcinoma, dysentery, mitral regurgitation, aortic insufficiency, dilatation of the heart, goitre, meningitis, epilepsy, locomotor ataxia, hemicrania, and diabetes mellitus.

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#### WHAT IS THE BEST NUTRITIVE ENEMA?

Nutritive enemata, though often indicated in cases of œsophageal or gastric disease, are comparatively rarely used, because of the general skepticism as to their utility. Either they are of but little nutritive value, as in the case of bouillon, or they are difficult of absorption by the rectum, as in the case of milk. Leube suggested, in 1872, the use of pancreatized beef-pulp, and afterward Ewald proposed the peptones of meat and of cheese as offering suitable material for rectal feeding. There is no doubt that the substances recommended by these writers are, in part at least, absorbed by the rectum. Nevertheless, their use has never become general, because of the difficulty of their preparation. Ewald, as a result of further

experiments, found that eggs, even though not peptonized, were to a considerable extent absorbed by the rectal mucous membrane. According to the *Mercure médical* for April 1st, Huber, of Zurich, has recently repeated Ewald's experiments in Professor Eichhorst's clinic, and announces that the absorption of the raw eggs is greatly aided by the addition of common salt. The salt is well borne, and causes, as a rule, no irritation of the bowel. He considers that eggs beaten up with salt, in the proportion of fifteen grains to each egg, are the best form of nutritive enema. His method of procedure is as follows: Two or three eggs are taken and thirty to forty-five grains of salt are added to them. They are slowly injected by means of a soft rubber tube carried as high up into the bowels as possible. Three such enemata are given daily. An hour before each enema the rectum is cleared out by means of a large injection of warm water.—*N. Y. Medical Journal*.

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#### COCAINE INCOMPATIBLES.

Cocaine is used in manifold mixtures, and often brought in contact with substances with which it is entirely incompatible. A. Bruner states that it is frequently prescribed with silver nitrate in ointments, when, as is probably not known to the prescriber, decomposition of the hydrochloride ensues with formation of insoluble chloride of silver, and a corresponding change in the cocaine. E. Schell, in the *El.-Loth. Journ. d. Pharm.*, reports that if calomel and cocaine hydrochlorate are rubbed together chemical reaction sets in. Mercuric oxide, too, if dispensed in form of ointment containing cocaine hydrochlorate changes, so that the ointment, instead of producing an anæsthetic effect upon the eyes, produces an exceedingly irritating one. This is due to the formation of oxy-chloride of mercury, the quantity of which depends on the amount of cocaine used, the intimacy of its mixture with the oxide, and the age of the ointment.—*Apoth. Ztg.—Journal American Medical Association*.

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#### SIMPLE TREATMENT FOR CHOLERA.

Dr. Harkin has proved the following method by actual experience: Blistering, collodion or any epispastre, is applied behind each ear and along the course of the pneumogastric nerve as far as the angle of the lower jaw. The object is to cause inhibition of the sympathetic in the abdomen by stimulating the vagus. The result is at once apparent: the purging

and other characteristic symptoms cease, and the patients fall asleep long before vesication takes place, and awake cured, or at least tidied over the dangerous period. Counter-irritation with mustard or spice leaves might be useful in a similar way in the treatment of cholera infantum.—*India Med. Gaz. Four. Amer. Med. Assn.*

#### WHAT SHALL BE DONE FOR A COLD IN THE HEAD.

It may not be always possible to break up a cold. Sometimes during the congestive stage, anything which will allay irritation will suffice. The person who feels a cold coming on should instantly betake himself to bed, drink a cup of hot ginger tea, and make use of a snuff like that which was proposed several years ago by Dr. Ferrier:

R. Morph. sulph .....	gr. j.
Bismuth subnit .....	3 iij.
Pulv. acacie .....	5 j. m.

The insufflation of a little morphine at the commencement of a cold in the head is sometimes attended with very happy results. Quinine as an abortant in commencing cold is much in use; the dose should be somewhat large; Dr. T. J. MacLagan says ten grains. Its efficiency is, however, rather problematical. Doubtless, menthol is one of the best local applications in the early stages of coryza. It may be used in the form of an ointment (menthol one part, vaseline thirty parts), or as a spray with liquid albolene. A formula which may do good service is the following: Menthol, one part; liquid albolene, thirty parts. A special spray atomizer, such as sold by all the instrument makers, is needed for the effective use of this combination. Menthol seems to limit congestion to the mucous membrane; it is often followed by a profuse flow of nasal mucous with little sneezing. Breathing through the nose and mouth the steam of hot camphor water, and the internal use of carbonate of ammonia are also recommended, and there is often utility in the production of active diaphoresis. Many, of late years, have claimed decided benefit from full doses of antipyrin, acetanilid, phenacetin, in the onset of cold; and, doubtless, these new remedies are more and more taking the place of the depressant diaphoretics.—*Boston Medical and Surgical Journal.—Four. Amer. Med. Association.*



PHILIP (R. W.) "ON THE TREATMENT OF PULMONARY  
TUBERCULOSIS."

*Edinburgh Medical Journal*, March, 1891.

Dr. Philip first touches upon catarrh of the respiratory passages in its relation to phthisis. When the ultimate vesicles are involved in this catarrh, the more or less stagnant mucopurulent secretion forms a good cultivation medium for the tubercle bacillus—hence an explanation of Niemeyer's doctrine on neglected catarrh.

Dr. Philip then divides phthisis from the point of view of treatment into three stages:

(1) *Catarrhal Stage Proper*.—Previous to the inoculation with the tubercle bacillus the treatment should be mainly prophylactic. "Colds" should be treated with attention and energy. Climatic treatment and well regulated gymnastic exercise should be made use of. Impure air, especially if it contain dust, will induce and prolong catarrhal state. It is in this stage that a knowledge of the life history of the organism is likely to bear the greatest fruit. Dr. Philip recommends the free use of arsenic in anæmia so often present at this period.

(2) *Stage of Invasion*.—Here the physical signs may be slight. The temperature is variable. Tubercle bacillus is found in the sputum. Here, besides tonic treatment, the question arises whether the cultivation medium can be made less suitable to the growth of the bacillus. The basis of the antiseptic treatment lies in this. Eucalyptus oil may be given with this object—ten to thirty minims three or four times daily. Dr. Philip says he has used the intra-tracheal injection frequently during the past three years, and that he finds it easy, safe and efficacious. Iodine, iodoform and salicylates are used with the same object. Sulphuretted hydrogen, administered by the rectum, also belongs to this same class of remedies. Bacterio-therapy is based on the antagonism of some micro organisms to others. It was first suggested by Cantani, but as yet the results are doubtful.

(3) *Stage of Absorption, or Phthisis Proper*.—The therapeutic indications cover much the same lines as in stage 2. The question of the possibility of surgical interference is touched upon. Dr. Philip recommends the use of belladonna in large doses in this stage.—*E. F. Trevelyan, in the Manchester Medical Chronicle*.

THE TREATMENT OF DIPHTHERIA.

VERNON JONES, M. B.

I should like to put on record a method which I have found exceedingly useful in the treatment of diphtheria; it

consists in the hourly spraying of the fauces and naso-pharynx with a saturated solution of baborate and bicarbonate of soda (about forty grains of each to the ounce of water). The rationale of the thing is, I believe, that the bicarbonate of soda tends to loosen and liquefy the tenacious mucus which is always present in these cases, and thus allows the borax to exert its action as an antiseptic; it is, of course, a weak antiseptic, but it has the advantage of being compatible with the bicarbonate, which I believe plays an important part as I have said above.

I have not the smallest doubt, in my own mind, that it tends to shorten the course of the disease; in fact, in one case the recovery was so rapid that I should have doubted my diagnosis if it had not been that a sister of the patient, who was living in the same house, had just died of the disease in St. George's Hospital.

In severe cases it is well to spray up the nostril to prevent the membrane spreading upwards, but for this the solution should be diluted, for if it is saturated with alkali it causes hyperæmia and soreness of the mucus membrane.

I must say, in justness to Dr. Soltau Fenwick, that in all my cases I have given iron, though only in one according to the prescription which he gives in the *British Medical Journal* for February 14.

It is now nearly two years since Dr. R. H. Coall mentioned the line of treatment to me: he tells me that he had used it for several years previously—in fact, it is to him that the credit is altogether due if the method should prove useful after a more extended trial.

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## OBSTETRICS.

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### PARTURITION IN A PRIMIPARA WITHOUT THE KNOWLEDGE OF THE PARTURIENT.

Brunon (*Four. de Méd.*, April, 19, 1891) reports a case which is important from a medico-legal point of view. It concerned a primipara, twenty-two years of age, who at termination of pregnancy was seized with quite severe lumbar pains one evening at nine o'clock, though the pains were not so severe that she or any one in her household thought of summoning a physician. At eleven o'clock she had a desire for an evacuation of the bowels, which kept her sitting in the water-closet for about an hour. After that time the lumbar pains diminished. At half past one the lumbar pains reappeared

with increased severity, with a feeling of heaviness in the ischiadic region, and a renewal of the desire to defecate. At this moment the patient endeavored to bring her thighs together, but was prevented by an obstruction which, upon examination, was found to be the head of her infant protruding from the vulva. At no time had the question of parturition occurred to her, and her first intimation as to what was going on was when she touched and saw the child's head between her thighs. The patient was a woman of calm temperament and good health and belonging to the cultivated class. There was nothing in her antecedents that would have any bearing upon this nearly painless labor. There was no abdominal colic at any time, there were no terminal expulsive pains, which are usually so severe; in fact, the only evidence of the process of parturition were the lumbar pains, the feeling of weight in the rectum, and the illusory desire to defecate. She stated that she might have given birth to her child in the water-closet had her friends not summoned her out after she had been in there some time. As to the medico-legal bearing of such cases, an inexperienced woman who did not realize what was going on might mistake the pains accompanying the dilatation of the uterus for a desire to evacuate the bowels and under these circumstances a child might be born and fall into a privy without the least intention of infanticide on the part of the mother.

—*N. Y. Medical Journal.*

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REPORT OF A CASE IN WHICH THE CHILD'S ARM BECAME  
ENGAGED IN THE FENESTRUM OF THE OBSTETRIC  
FORCEPS.

By DAN MILLIKIN, M. D., of Hamilton, O.

Nearly a year ago I attended a woman who had borne four dead children after severe and complicated labors, each time under the care of a different physician. She had also borne one living child, which owed its existence to the fact that it was very small, and probably was prematurely born. This woman, half through her sixth pregnancy, came to me, and consented to the induction of premature labor. Thereupon she passed from my notice, changed her plans upon ill-advice, and summoned me when labor at term had progressed for two or three hours.

When the cervical tissues were in proper condition, a careful examination of the case was made under an anæsthetic. Finding a head of moderate size above the brim of the pelvis in left occipito-anterior position, I was sure that I could deliver it with forceps in spite of a slight asymmetry, and a shortened



antero-posterior diameter of the pelvis. In this opinion I was all amiss, for it was afterward demonstrated that the child could not be delivered in that position, and it also appeared that it could be delivered easily feet foremost. But this error of judgment is somewhat apart from my present business.

Four fingers were passed, and the forceps were carefully guided to the sides of the child's head. They were easily locked and manifested no disposition to slip during the attempted extraction of the child. It may also be remarked that they were my pet instruments, with broad blades and strong curves, cephalic and pelvic.

No effort was made to induce pains by traction. The pains were very vigorous but separated by unusually long intervals. For this reason, and because the woman's general condition was excellent, the effort to deliver by forceps was much prolonged.

When, finally, it was determined to essay delivery by podalic version, a state of affairs was presented which, so far as I can learn, was unique in obstetric practice. The upper blade of the forceps—that one which passed to the right side of the woman's pelvis—would not come out! The lower blade was withdrawn first, and without difficulty, but still the other would not come away. Then my hands, passed into the uterus, revealed the fact that the child's right hand had passed through the fenestrum of the blade and that, in fact, the blade hung on the bend of the elbow, as a basket hangs on one's arm. The blade could not have been withdrawn without internal manipulation.

Presently, when the child had been delivered by the feet, it was seen that violence had been done to the forearm alone, and that the injury was near the elbow. No bones were broken, but the soft parts were terribly crunched. Undoubtedly, if the instrument had been long and stiff, and if it had appeared proper to compress the head very severely, the arm would have been completely chewed off.

Endeavoring to draw some warning from such a sorry job, we may note, in the first place that the accident could only occur when a suprapelvic application of the forceps is made. To attain the odd position in which I found it, the arm must have lain for a moment with its palmar surface on the convex surface of the forceps blade as it was about to be applied to the head; then the hands must have dropped into the fenestrum, and finally, the forearm must have been flexed upon the arm by the final thrust of the blade home to its position. All of these evolutions require room, and could only occur above the brim.

In the second place, I would remark that the accident can not possibly be diagnosed unless the head and arm are above the ordinary size. In my case the forceps were easily introduced and locked with the greatest ease; the handles were approximated as much as in the average case; there was no disposition to slip, neither when the forceps were in my hands nor in the hands of my skilled associate, Dr. Geo. C. Skinner; the child's head and the points of the forceps were repeatedly and carefully palpated through the thin abdominal and uterine tissues, and no suspicion of this unique complication arose in our minds. I can not believe that the most expert and experienced obstetrician could have detected the presence of the arm in the fenestrum until he attempted the withdrawal of the instruments.

For this reason I am in the humor to inquire whether the fenestrum has any reason to exist. What is it good for, anyway? It has been said in most of the systemic treatises that the fenestrum gives lightness to the forceps, but this proposition, which is at first glance very plausible, admits of question. Give to me a solid blade that is admittedly too heavy, and I can lighten it either by cutting out a fenestrum or by grinding it thinner. If I cut out the fenestrum I weaken the blade, past question, and may need to thicken the remaining metal to restore the lost strength. Any instrument shop will furnish samples of forceps which have passed through this line of development; that is to say, they are light blades with generous fenestra and metal altogether too thick. And after all, what signifies weight in obstetric forceps? Ordinary forceps, fenestrated or non-fenestrated, need not weigh more than a pound, and it is easy to make a long pair of crushing instruments with a pound and a half of steel. Surely the brother who can not carry a pair or two of this weight is not stout enough to be out at night, much less to use forceps.

On behalf of the fenestra it has been said, further, that they permit prominent parts of the head to engage in them—the parietal eminences, for example—in such a manner that the forceps occupy no available room, take a much better hold upon the head, and obviate the tendency to slip. To this it may be responded in the way of argument, that it is a remarkable streak of luck, and nothing but luck, when the prominences on a child's head project into the fenestra. It may be said, further, that forceps rightly chosen and rightly used for the case in hand do not occupy any available room nor, when in use, increase the diameter of the child's head, measured between the blades. Fenestrated or non-fenestrated, they *make* room, moulding the head by compressing it to such

a degree that were they of double thickness they would find room. And, finally, as to the slipping of the forceps, it may be said that when they show an inveterate tendency to slip, either the forceps or the operator should be changed; there is something amiss in the fit, the application or the manipulation. Fenestra will not prevent slipping when the forceps have not been placed upon the child's head, nor when they are used merely as tractors.

And it may be urged further, that when we cut fenestra in our forceps we increase the total amount of edge surface. This is a positive disadvantage which should be atoned for by some very great advantage. Examining the head of a child which has been the subject of a severe forceps extraction, one will find that the narrow rim of metal about the fenestrum has shown a tendency to actually cut into the tissues of the scalp. Not only the outer, convex, marginal edges make their mark, but also in lesser degree, the inner, concave edges which bound the fenestrum. Looking at such a specimen one would incline to the opinion that the fenestrum is an evil.

But waiving the question as to whether the fenestrum has any reason to exist, I think that my mishap in the case cited gives us reason to cease operating above the brim with forceps having wide fenestra.—*Journal Amer. Medical Association.*

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#### SUBCUTANEOUS INJECTIONS OF CAFFEINE IN THE TREATMENT OF PUERPERAL HEMORRHAGE.

Misrachi (*Jour. de Med.*, March 8, 1891,) recommends this method of using caffeine for cases of post-partum hemorrhage in which a rapid effect is required. It is of special advantage to the country practitioner, who may at the time be attending cases of infectious disease, and whose hands may not be sufficiently disinfected to justify a digital examination of the genital organs of the parturient patient. The author states that caffeine will act more rapidly than ergot and more efficiently than ether, though the latter is more rapid in its action as a stimulant. The caffeine should be administered in a solution containing a grain and a quarter of the substance, and this may be repeated if necessary until five grains have been used. A better solution may be obtained by dissolving the caffeine in warm water with benzoate of sodium. It is recommended that packages containing both these materials form a portion of the contents of the obstetrician's bag.—*N. Y. Medical Journal.*



## Book Reviews and Notices.

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*Principles of Surgery.* By N. Senn, M. D., Ph. D., Milwaukee, Wis., Professor Principles of Surgery in Rush Medical College, etc. Illustrated with 109 wood engravings. Philadelphia and London: F. A. Davis. 1890.

Without exaggeration, Senn's book may be said to be the most notable contribution to surgical literature that has appeared since antiseptis revolutionized the science and art of surgery. It is the only work of the kind in the English language; and, on account of the broadness of the principles laid down and the originality of the author, it may come to mark an epoch in modern surgery.

Many great minds have shed light on various questions connected with the surgeon's art. Each one has added something to the great mass of material which makes up modern surgery; but it was left for Senn to digest the vast literature that had accumulated, and combine apparently disconnected fragments into a harmonious whole. Senn did not introduce antiseptic surgery, neither did he establish bacteriology; but he has carefully considered all the valuable material that other investigators have amassed, and from this he has elaborated a work that will always stand as a clear and vigorous exposition of the broad fundamental principles upon which a rational system of surgical procedure may confidently be built. Senn's work gives the essence of advanced modern surgical doctrine on all points except tumors, which the author reserves for a subsequent work.

In the opening chapter of his book on *Regeneration*, Senn boldly distinguishes between repair and inflammation. Inflammation, according to Senn, is always caused by the presence of one or more kinds of pathogenic bacteria; no bacteria, no inflammation. "As compared with true inflammation it has been customary for quite a number of years to speak of regeneration as a plastic or regenerative inflammatory process; but the term *inflammation* in the future should be limited to the series of histological changes, which ensue in the living body from the presence and action of specific microorganisms, while the word *regeneration* should be used to designate the histological changes which take place in tissues which are primarily in aseptic condition, or have been rendered so after the inflammation has subsided." Bacteriology here offers the greatest assistance to surgery. The part played by bacteria in the causation of disease is clearly set forth by

Senn, the material for this portion of the work being drawn from his "Surgical Bacteriology."

We can not quote from all of the chapters, for there is so much that is worth quoting that this notice would swell to the size of the book itself. Suffice it to say that Senn's work is a résumé of the principles of modern surgery, set forth with the clearness, originality and virility characteristic of the man.

A. McS.

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## Medical Items.

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### DOCTOR OF LAWS—A DESERVED HONOR CONFERRED ON A DISTINGUISHED DOCTOR.

[*Courier-Journal*, June 18.]

His many friends and admirers in this and other states will be glad to learn that the University of South Carolina yesterday conferred the degree of doctor of laws on Dr. F. Peyre Porcher, the eminent physician, distinguished botanist and cultured gentleman of this city.

Dr. Porcher's eminence in his profession is conceded outside of his native state, and his ripe scholarship in the field of letters is evidenced by occasional addresses and articles for the newspapers, which he has found time to prepare between the busy moments of a practising physician's life; but it is probably in recognition of his exhaustive researches and publications in the department of botany that his alma mater yesterday conferred the well-merited honor of doctor of laws on Dr. Porcher.

Some idea of the extent and variety of Dr. Porcher's contributions to botany and medicine may be drawn from the following partial list taken from the "Index catalogue of the library of the Surgeon General's office" of the United States army, published in 1890:

Porcher (Francis Peyre), [1824]—"The medicinal, poisonous and dietetic properties of the cryptogamic plants of the United States, being a report made to the American Medical Association—126, pp. 80, New York; Baker, Godwin & Co., 1854. Repr. from Tr. Am. M. Assoc., N. Y., 1854, vii.

Prize essay, February, 1860. Illustrations of disease with the microscope. Clinical investigations, aided by the microscope and by chemical reagents, with microscopical observa-

tions of pathological specimens, medical and surgical, obtained in Charleston, S. C. Pt. 1, 133, p. 1, Tab. 80. Charleston: Evans & Cogswell, 1861..

Resources of the Southern Fields and Forests, Medical, Economical and Agricultural. Being also a medical botany of the Confederate States, with practical information on the useful properties of the trees, plants and shrubs. Prepared and published by order of the Surgeon General, Richmond, Va. XXV, 601 pages, 8 octavo. Charleston: Evans & Cogswell, 1863.

The same. New edition. Revised and largely augmented; 673 pages, 8 octavo. Charleston: Walker, Evans & Cogswell, 1869.

Yellow Fever in Charleston, 1871, with Remarks upon its Treatment. President's address before South Carolina Medical Association, 30 pages, 8 octavo. Walker, Evans & Cogswell, 1872.

Dr. Porcher was co-editor of the *Charleston Medical Journal and Review*, 1850-55: new series, 1873-77; and prepared an examination into the medicinal and chemical properties of the *Sarracenia flava* and *variolaris* (fly trap), in *Charleston Medical Journal and Review*, Vol. IV, 1849. Numerous articles and reviews in the *Charleston Medical Journal and Review*, in the *American Journal of the Medical Sciences*, and the *Medical News of Philadelphia*, an illustrated paper on "The Edible and Poisonous Fungi" of the United States, published in *Wood's Hand Book of the Medical Sciences*, New York, W. C. Wood & Co., attracted deserved attention.

During the war Dr. Porcher was surgeon to the Holcombe Legion to the Confederate Hospital, Fort Nelson, Norfolk harbor and the South Carolina Hospital, Petersburg, Va.

One of his most admirable efforts in the literary vein was an address before the Association of the Survivors of the Confederate Surgeons of South Carolina, at the annual meeting held at Columbia, S. C., in November, 1889.

#### HONORARY DEGREES.

Doctor of Laws—Prof. Francis Peyre Porcher, M. D., Charleston.

Doctor of Divinity—Rev. William Robert Atkinson, A. B., Columbia.



## MORTUARY REPORT OF NEW ORLEANS.

FOR MAY, 1891.

CAUSE.	White .....	Colored..	Male.....	Female.....	Adults ...	Children ..	Total .....
Fever, Yellow .....							
“ Malarial (unclassified)....	4	3	5	2	3	4	7
“ Intermittent .....	3	1	1	3	2	2	4
“ Congestive.....	4		3	1	4		4
“ Typho-Malarial.....	4		3	1	4		4
“ Typhoid or Enteric.....	2	1	3		2	1	3
“ Puerperal.....		1		1	1		1
Scarlatina .....							
Small-pox.....							
Measles .....	10	3	7	6		13	13
Diphtheria .....	1	1	2			2	2
Whooping Cough .....							
Meningitis .....	14	2	11	5	2	14	16
Pneumonia.....	24	11	27	8	20	15	35
Bronchitis .....	3	7	5	5	2	8	10
Consumption.....	35	28	36	27	58	5	63
Cancer .....	9	1	3	7	10		10
Congestion of Brain.....	9	4	5	8	6	7	13
Bright's Disease (Nephritis) ..	15	7	15	7	21	1	22
Diarrhœa (Enteritis) .....	43	25	36	32	19	49	68
Cholera Infantum .....	75	19	54	40		94	94
Dysentery.....	6	1	5	2	6	1	7
Debility, General .....	3	1	2	2	4		4
“ Senile .....	14	14	5	23	28		28
“ Infantile.....	7	7	7	7		14	14
All other causes .....	202	93	161	134	186	109	295
TOTAL .....	487	230	396	321	378	339	717

Still-born Children—White, 19; colored, 17; total, 36.

Population of City—White, 184,500; colored, 69,500; total, 254,000.

Death Rate per 1000 per annum for City—White, 31.13; colored, 39.71. total, 33.87.

HENRY WILLIAM BLANC, M. D.,  
Chief Sanitary Inspector

## METEOROLOGICAL SUMMARY—MAY.

STATION—NEW ORLEANS.

Date.....	TEMPERATURE.			Precipn. in inches and hundredths..	SUMMARY.
	Mean	Max..	Min..		
1	75	81	65	0	Mean barometer, 30.070.
2	72	80	65	0	Highest barometer, 30.296, 21st.
3	75	83	67	0	Lowest barometer, 29.852, 27th.
4	77	84	70	0	Mean temperature, 73.8.
5	74	83	67	0	Highest temperature, 89, 24th; lowest, 53, 7th.
6	68	74	63	T	Greatest daily range of temperature, 23, 16th.
7	62	72	53	0	Least daily range of temperature, 11, 6th.
8	66	74	57	0	MEAN TEMPERATURE FOR THIS MONTH IN—
9	69	77	61	0	1871.....73.2    1876.....74.6    1881.....76.8    1886.....72.6
10	70	79	62	0	1872.....75.6    1877.....72.5    1882.....74.4    1887.....75.2
11	72	81	63	0	1873.....73.7    1878.....75.9    1883.....74.3    1888.....72.8
12	72	78	66	.61	1874.....75.4    1879.....70.5    1884.....76.4    1889.....73.8
13	68	75	62	.14	1875.....76.0    1880.....76.3    1885.....73.0    1890.....74.1
14	70	77	63	0	1891.....73.8
15	72	81	64	0	Total deficiency in temp'ture during month, 44.
16	73	84	62	0	Total excess in temp'ture since Jan. 1, 55.
17	74	83	66	0	Prevailing direction of wind, S. W.
18	74	80	67	0	Total movement of wind, 6004 miles.
19	74	82	66	0	Extreme velocity of wind, direction, and date,
20	76	83	69	T	35 miles, S. E., 4th.
21	75	83	67	0	Total precipitation, 0.76 inches.
22	77	85	69	0	Number of days on which .01 inch or more of
23	78	85	70	.01	precipitation fell, 3.
24	82	89	74	0	TOTAL PRECIPITATION (IN INCHES AND HUNDREDTHS)
25	79	88	70	0	FOR THIS MONTH IN—
26	78	87	68	0	1871..... 5.08    1876..... 7.10    1881..... 3.20    1886..... 3.97
27	80	87	72	0	1872..... 3.14    1877..... 1.48    1882..... 6.83    1887..... 3.99
28	76	83	68	0	1873.....18.68    1878..... 8.11    1883..... 5.41    1888..... 9.75
29	76	84	68	0	1874..... 0.22    1879..... 4.03    1884..... 4.33    1889..... 1.17
30	76	84	69	0	1875..... 2.53    1880..... 6.55    1885..... 5.77    1890..... 5.32
31	78	85	70	0	1891..... 0.76
					Total deficiency in precip'n during month, 4.56.
					Total deficiency in precip'n since Jan. 1, 11.22.
					Number of clear days, 23; partly cloudy days,
					8; cloudy days, 0.
					Dates of Frost, .....
					Mean maximum temperature, 81.6.
					Mean minimum temperature, 65.9.

NOTE.—Barometer reduced to sea level. The T indicates trace of precipitation.

G. E. HUNT, Sergeant, Signal Corps Observer.

Do not fail to read our Proposition at the bottom of page.\*

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*Medical Letters may be addressed to:*

Mr. FELLOWS, 48 Vesey St., New York.

August, 1891.

*Paullum sepultæ distat inertie  
Celata virtus.*—HORACE.

# New Orleans Medical and Surgical Journal.

Augustus McShane, M. D.,

Editor and Publisher.

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# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

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## Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the first day of the month preceding that in which they are expected to appear. A complimentary edition of twenty-five reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a written order for the same accompany the paper.]

### A CLINICAL REPORT ON INTRAVENOUS SALINE INFUSION IN THE WARDS OF THE NEW ORLEANS CHARITY HOSPITAL FROM JUNE, 1888, TO JUNE, 1891.\*

BY RUDOLPH MATAS, M. D., VISITING SURGEON, ETC.

[CONCLUDED.]

#### PART II.—REMARKS.

In the preceding clinical report it will be noticed that in no case has a real transfusion been performed, and that in all cases in which transfusion of blood would possibly have been indicated intravenous saline infusion has been uniformly substituted and preferred. The practical and theoretical reasons for this preference while admitted by many are still the subject of contention, and deserve, if for this reason alone, some passing consideration and explanation.

It should also be remembered that the term *transfusion* should be restricted, as Roussel first indicated, to that method of intravascular medication by which the blood of one person or animal is transferred from the vascular system of one into the vascular system of the other and that the term *infusion* (*intravenous*, *intra-peritoneal* or *subcutaneous*) should be restricted to all cases in which other solutions or media than

---

\*Read before the Louisiana State Medical Society, May, 1891. (Part I appeared in the July issue of the JOURNAL.)

blood are introduced. The injection of blood also, if not done directly into vascular system as in the subcutaneous injection of blood (e. g., Karst's or V. Ziemessen's method), can not properly be called transfusion.

\* \* \*

Long ago, in the earlier years of the century, the need for a liquid and neutral menstruum that would be able to dilute the thick clogging blood of choleraic patients who were manifestly dying *asphyxiated* not for a want of oxygen-carrying corpuscles but simply because these could not be floated to their destination, owing to the dehydration of the blood and tissues, suggested the use of intravenous saline infusions which were first successfully practised by Jœnichen, of Moscow, in 1830.\*

But the later experiments of Schiff and Gaule, which proved the stimulating and re-animating influence of saline solutions on the frog's heart when severed from the body, and the subsequent experiments on exsanguinated animals by Jolyet and Laffont, and the still later and confirmatory observations of Kronecker, Hayem and Fournac, led to the clinical adoption of saline infusion as a restorative method in cases of acute surgical anæmia. Bischoff, who saved a woman moribund from post-partum hemorrhage, after injecting 1250 grammes of salt solution, and the subsequent successes achieved by Kustner, Kocher, Kussmaul, Pellacani, and W. Bull, not only established the clinical utility of saline infusions, but also demonstrated that the respiratory and hæmic value of transfused blood was not as essential to the complete restoration of persons dying from the effect of acute traumatic anæmia as had been at first supposed.

\* \* \*

Without attempting to establish a lengthy parallel between the older practice of transfusion and the more modern method of saline infusion for the restoration of patients threatened with death from the rapid depletion of their vascular system, we may at once ask: is this saline infusion a true rival or a mere succedaneum of blood transfusion? We must answer *yes* and *no*, according to certain circumstances.

---

\* *Vide* Menard, Art. Transfusion, Dict. Dechambre.

We must at once state that *mechanically* or *physically*, saline infusion are the rivals or equivalents of blood transfusion, while *physiologically* they never can rival or equal the value of blood.

In speaking of blood as a medium for transfusion we mean, of course, only pure, entire, living blood and not the altered pathological material known as defibrinated blood. We also mean blood of the same species and not that derived from heterogenous sources.

Now the superiority of entire and living blood is based on three qualities, viz: 1. Its nutritive. 2. Its respiratory. 3. Its hemogenic value.

None of these qualities, except the last perhaps, are possessed by the inorganic saline solution. Consequently we need not discuss further the physiological superiority of blood which is here unhesitatingly admitted.

But it happens in surgical practice that in many, if not the vast majority of the cases of acute anæmia in which fatal syncope threatens life through vascular depletion, that the cry of the moment is not for physiological restitution so much as for the *mechanical* dilution of the blood remaining in the vascular system and tissues of the individual; under these circumstances, the true value of saline solutions is made clear and its position as a true rival of the more costly blood can be readily appreciated.

\* \* \*

The question of the utility of neutral saline solutions and their ability to save the life of patients apparently moribund from loss of blood having been decided in the affirmative by superabundant clinical experience a more important problem remained to be solved and that was, what was the limit of this life-saving power. When could the action of the saline solution be expected to be permanent and when only transitory or ephemeral?

This problem was easily solved by the physiologist in his experimental laboratory but not so readily by the clinician.

The physiological limit of blood loss compatible with life has been the object of interesting and serious experimental study. From the earlier studies of Herbst (1822) to those of Renaut, Hayem, Wanner and Kermisson to the latest calcula-



tions of Rosenberg, we may admit that animals can survive the rapid loss of two-fifths of the total quantity of their blood, while the loss of more than two-fifths and less than one-half is *usually*, and more than one-half *absolutely* fatal. In his experimental use of the .7 per cent. salt solution this investigator was led to think that the injections only *temporarily* prolonged life in hemorrhages beyond one-half the total quantity of blood. This, he believed, was due to the reduction of the absolute number of corpuscles in a given bulk, resulting in a *qualitative* anæmia.

If we calculate with Bayard Holmes on Rosenberg's data, "and assume that a loss of one-half of the blood is ultimately fatal, even if infusion and resuscitation is practised, we should have a reduction in the corpuscular elements to one-half, a fatal reduction. As there are ordinarily 5,000,000 corpuscles to a cubic millimeter of blood, a loss of one-half the blood and a restoration by infusion of its bulk to the full amount would reduce the corpuscles to 2,500,000. This number has been found clinically to be compatible with life, and a fair degree of vitality. Patients recover with a presence for months of less than 2,000,000 corpuscles per cubic millimeter. But a reduction beyond 1,500,000 is usually rapidly fatal, and death occurs before the number falls below 1,000,000 to a cubic millimeter."

While this estimate of Holmes may be correct for an acute experimental or surgical anæmia it is possible that the number of corpuscles may even suddenly be reduced below these figures, and the condition be still compatible with life. In this connection the interesting observation of William Hunter should be remembered, as he has found that in certain hæmolytic diseases of the blood, such as chlorosis and pernicious anæmia, "the number of red corpuscles may be reduced to 500,000 or 600,000 instead of the full 5,000,000 to the cubic millimeter which characterize health, and yet the respiration of the individual will not appear to be perceptibly affected."

\* \* \*

But while admitting that the physiologist may determine the precise limit of life compatible with blood loss, and thus equally determine the critical conditions in which life may be permanently or ephemerally maintained by simple dilution, it

is otherwise with the clinician, who is almost invariably called upon to rescue a patient who is laboring under a complexity of conditions that are far from representing the simple condition of the laboratory experiment.

It must be generally conceded that there are few cases, indeed, of acute traumatic anæmia in which death is threatened from pure asphyxia due to corpuscular deficiency and the consequent *respiratory* inadequacy of the blood. Death, in the majority of the cases, we repeat, is threatened and will actually take place long before the corpuscular limit has been reached. It is *syncope*, *initial circulatory failure*, and not asphyxia from lack of corpuscular respiration, that kills in acute traumatic anæmia and it is this condition that the clinician endeavors to antagonize by the timely exhibition of the saline plethorifacient.

Hunter,\* a justly eminent English authority, has very correctly stated the case in a recent contribution: (1) "The value possessed by transfused blood in such cases is almost solely in virtue of its *physical* properties. The chief physical property of blood for purposes of transfusion is undoubtedly its volume. The immediate source of danger from sudden loss of blood is the fall of the blood pressure to a point where the circulation is unable to be maintained. The obvious indication, therefore, is to raise the pressure within the vessels. In health, the blood pressure is dependent mainly upon peripheral resistance.

"The effect of the loss of blood on the blood pressure is, up to a certain point, completely neutralized by an increase in the peripheral resistance, due to the stimulation of the vasomotor centers. It is only after very severe hemorrhage that the relation between the vessels and the amount of fluid they contain necessary for carrying on the circulation is disturbed. The pressure then falls rapidly and suddenly, and death will ensue unless means be taken to meet the threatened failure of the circulation. The readiest way in which this can be done is to replace the lost blood with a certain bulk of fluid. To meet the danger thus arising the amount of blood is more important than its quality.

---

\*On Transfusion; its Physiology, Pathology, Practice, three lectures delivered before the Royal College of Surgeons, by Wm. Hunter, M. D., etc. British Med. Jour., April 10, 1889.

“In an emergency, the infusion of ordinary water (Coates) has been followed by results as successful as any ever obtained after transfusion of blood. Bulk for bulk, pure or defibrinated, blood must possess certain advantages over neutral saline solutions free from organic constituents. This doubtless possesses a certain physiological as well as physical value, inasmuch as blood must have a greater and more immediate effect in restoring the tone of the vaso-motor centers than saline solution.

“These advantages are more than neutralized by other and greater disadvantages, namely, (1) The difficulty of obtaining blood in sufficient quantity or with sufficient rapidity as compared with the ease with which simple saline solution can be prepared. (2) The dangers attending the transfusion of blood compared with the absolute freedom from danger possessed by the solution, and (3) the doubtful value of the transfusion, whether hæmogenic or physical, when compared with saline solution.” -

The physiological need of blood as a medium for the restoration of the vascular equilibrium in acute traumatic hemorrhage having been largely disproved and the physical reason for intravascular injection in such cases being better understood, we can easily appreciate the growing popularity and general substitution of salt water for blood media.

\* \* \*

Returning now to the clinical aspect of this subject we must note that a certain amount of shock is almost inseparable from the acute anæmia that the surgeon is called upon to meet, and we may at once state that it is the proportion in which this element of shock is added to the anæmic element that, as a general rule, decides the permanency of the therapeutic benefit obtained by saline infusion. From the limited experience furnished by the nineteen cases reported in the first part of this paper, and a careful consideration of many other cases scattered in the literature of this subject, I have been struck with the importance of the role played by shock in deciding the final issue of the case. So forcibly have I been impressed with this observation that I believe we may safely formulate this proposition, viz: That the greater the shock complicating a



case of surgical anæmia the less the benefit of infusion and conversely, the more uncomplicated the anæmia the greater the probabilities of final and permanent recovery with infusion. The reasons for this fatal influence of shock is readily understood when we consider that the most striking manifestation of this condition is a cardio-vascular inhibition, amounting to a true circulatory paresis or even complete paralysis in the fatal cases. Shock not only weakens the cardiac pump itself but interferes most injuriously with the contractility of the peripheral vessels, and thereby with the compensating mechanism which plays so important a part in maintaining a safe degree of vascular tension in uncomplicated hemorrhage.

Previous exhaustion preceding operative procedures from acute or chronic suppurative and septic processes are also certain to neutralize the permanent benefits of saline infusion when applied for the relief of the vascular depletion consequent upon traumatisms.

These statements are well illustrated in the cases detailed in the preceding pages. Thus the effect of pure shock complicating hemorrhage is well shown in cases 1 (Amputation of Thigh for Sarcoma), 8 (Multiple Fracture of Skull), 6 (Avulsion of Arm), 12 (Supra-vaginal Hysterectomy for Myoma), 13 (Laparotomy for Gunshot Injury of Abdomen), 19 (Disarticulation of Hip for Comminuted Gunshot Fracture of Femur). While the exceedingly transitory benefit of infusion in *uncontrolled* hemorrhage is particularly well exhibited in cases 4 (Gunshot of Head, Wound of Cerebral Sinus), 11 (Unrecognized Stab of Internal Mammary Artery).

The effect of acute or chronic exhaustion (from suppuration or sepsis, etc.) as unsuccessfully met by infusion are also shown in cases 9 (Acute Dysentery), 14 (Disarticulation of Shoulder for Fractured and Suppurating Limb), 17 (Amputation of Leg for Fractured and Suppurating Limb).

On the other hand, the brilliant and permanently beneficial effects of saline infusion in cases of syncope from pure and less complicated hemorrhages are admirably illustrated in cases 2 (Wound of Axillary), 3 (Idiopathic Epistaxis), 4 (Secondary Hemorrhage after Syme's Amputation), 7 (Sec-

ondary Hemorrhage after Osteotomy for Overlapping Fracture of Femur), 18 (Stab of Brachial Artery).

From the further analysis of the cases here reported it is seen that the immediate or temporary effects of saline infusion were always good, no matter what was the cause of the vascular depletion. In the majority of the cases patients apparently moribund were revived, and in at least two instances practically dead patients whose hearts had ceased beating perceptibly, and who even had ceased breathing, were resurrected and made to return to life and consciousness by the timely stimulation of the circulatory centers and organs through the agency of the infusion. This impressive result was obtained in case 9 especially, though in both instances the brilliant result was only temporary, though sufficiently prolonged to have permitted the patients to recognize their surroundings and to have made a final disposition of their affairs, had they so desired it.

It can not, furthermore, be doubted from the evidence furnished by these observations that in all cases in which life is threatened by cardiac syncope, *i. e.*, in which the arteries are empty, whether due to vascular depletion or to loss of the contractile energy of the heart, whether from hemorrhage, shock or exhaustion, that saline infusion is a most potent restorative, producing almost invariably an immediately favorable effect. The question of the permanency of this effect is, however, as already indicated, far from being so satisfactory, as is also well shown by this report. Here so many factors of a physiological and pathological character intervene in the solution of the problem that it is practically impossible, in many cases, to be able to foresee with certainty the ultimate effect of this mode of therapeutic intervention. Nevertheless, *a priori* reasoning and the results of experience have taught us what to expect from saline infusion in the majority of cases, so that the indications and final prognosis may be pretty accurately defined, as we have attempted to do, in the following conclusions which we have drawn as the result mainly, of our hospital experience.

#### CONCLUSIONS.

1. In all cases in which life is threatened by circulatory failure, from any cause, saline infusion may be depended upon as a *temporary* restorative.

2. Saline infusion will act as a *permanent* as well as temporary restorative in all cases of syncope due to simple and uncomplicated hemorrhage.

3. In all cases of uncontrollable hemorrhage, in which the flow of blood can not be arrested, the beneficial effect of saline infusion must necessarily be ephemeral, though even under these circumstances an artificial circulation of short duration will be maintained which may sustain life long enough to be of value.

4. Saline infusion *may* restore permanently, as well as temporarily, in cases in which syncope threatens life from mixed vascular depletion (hemorrhage) and cardio-vascular paresis (shock) though the permanency of the effect will depend largely on the degree of the shock. The greater the shock the less permanent the beneficial effect.

5. In all cases in which syncope is due only to cardio-vascular paresis or paralysis (shock) the effect of infusion is of very doubtful value and is almost always extremely ephemeral and rarely permanent.

6. In all cases in which syncope is due to organic (nutritive) as well as dynamic alterations in the cardio-vascular apparatus (e. g., exhaustion from disease) the effect of infusion will always be ephemeral and never permanent, though even in these cases the restorative effects of infusion are worthy of remembrance.

\* \* \*

Having stated the reasons for preferring the method of saline infusion for that of blood infusion, and its indications, let us now consider its technical application.

Much stress has been laid lately on the superiority of subcutaneous infusion over the intravenous method. My friend, Dr. Bayard Holmes, of Chicago,\* has proven himself an able advocate of the subcutaneous method, and there is no doubt that by availing ourselves of the Allen surgical pump, which he recommends for the purpose, the injection of salt water into the subcutaneous tissue is indeed an easy and safe procedure. But while admitting that subcutaneous infusion is an easier and possibly safer procedure in the hands of the inexperienced, I can not admit that it is altogether superior, or

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\* *Vide* this journal for March, 1891, p. 695-701.



even equal in any way to intravenous infusion when this is practised by a careful operator. Among the now salient advantages of the intravenous method we must recognize, (1) its immediate penetration into the circulation and certainty of absorption; (2) it is almost unrestricted in its possibilities, as far as the quantity injected; (3) it is comparatively much less painful than the subcutaneous method; (4) it requires the simplest and most readily improvised apparatus for its performance. In our hospital practice we have generally used a very simple contrivance, which was first mounted by Dr. F. W. Parham when assistant house surgeon of the institution. It consists simply of a large glass funnel to which a long drainage tubing is attached, the lower end being inserted to an elongated metallic tip which serves as a nozzle.\* The flow in the tube is controlled either by the finger of an assistant or by an ordinary wooden spring clamp. The tip also may be improvised very successfully by utilizing the fine end of a long, narrow glass nozzle, such as is found in most fountain syringes. Nothing, therefore, can be easier to prepare than this simplest of transfusion instruments.

Now as to the *modus operandi*. This is equally simple: (1) *Disinfect* thoroughly the bend of the elbow with soap, hot water, ether and sublimate. (2) Expose a subcutaneous vein, the most prominent in sight, either the median cephalic or basilic. The exposure should be effected by making a linear incision  $2\frac{1}{2}$  inches parallel to the vein, so that the cut can be readily placed over the vein by simply sliding the loose skin over the vein. (3) *Isolate* the exposed vein by passing a grooved director under it. (4) Ligate the vein with catgut one inch below (peripheral side of) the proposed puncture. (5) *Introduce* a silk or catgut ligature under the vessel about one-half an inch above (cardiac side of) the proposed puncture and leave it without tying. (6) Open the exposed vein by making a small valvular nick in it with sharply-pointed scissors, the anterior vein-wall being pinched up for the purpose by a fine-bladed dissecting forceps. (7) *Introduce* the canula of the apparatus, after having previously allowed the saline solution to flow out of the tip, so as to secure the complete exclusion of air. (8)

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\*The use of a glass funnel with these accessories is probably a very old one. The instruments of Bellina, Colin, Galabin and Cripps suggest the same plan.

Tie the proximal end of the vein with the second ligature that was ready for the purpose, and include the tip of the apparatus in the ligature. (9) Now allow the liquid to flow.

In the practice of saline infusion it is also important that (1) the receptacle destined to contain the fluid be perfectly aseptic; (2) that the fluid to be injected be thoroughly sterilized; (3) that the solution be clear and heated to about 100°; 100½° F., (Hayem); 104° F., (Esmarch); 104° F., (Lorain); 107.6° F., (Lotta); (4) that the solution of salt in water do not exceed 7 to 1000 parts; (5) the fluid should not be injected too rapidly, the velocity of the stream being regulated by the length of the conveying tube and the height of the apparatus. Esmarch estimates that three fluid drachms per second should constitute the rate of injection; (6) the quantity injected should depend upon the general effect, especially upon the circulation, guided by the pulse. The rule should be to inject for the effect; *i. e.*, the return of the normal arterial tension without special regard to quantity, fifteen to thirty ounces being usually the quantity required in adults to produce a satisfactory impression.

In this connection, I should notice that larger quantities of salt solution are required and tolerated by the vascular system than in blood transfusion. Worm-Müller, Landois, Lesser, have been able to double, even treble the total amount of the systemic blood mass without dangerously increasing the intra-vascular pressure. In these cases the injections have been made very slowly. Oré (Jaccoud's Dict.) as a result of numerous experiments on dogs established the fact, based on the circulation that the total blood weight is equal to 1-10 the total body weight, that 1-20 of the total blood (or 1-200 of body weight) could always be *transfused* without any perceptible inconvenience.

Any way, in saline solution there are none of the dangers encountered in the injections of blood, and for this reason the amount injected should be almost entirely regulated by the effect on the pulse. When the pulse becomes nearly normal in frequency and volume, then stop.

No more striking illustration of the receptive capacity of the vascular system with reference to saline infusion

could be quoted than the case recently reported by Dickinson to the London Medical Society, February 28, 1890. (British Medical Journal, March 8, 1890.)

The case was one of diabetic coma in a woman aged 25 years. Intravenous infusion with a solution consisting of sodium chloride, potassium chloride, sodium sulphate and bicarbonate dissolved in water. This was slowly injected by means of a syringe, first into the right arm, then into the left until, in the course of one hour and a half, 106 ounces had been introduced. About ten minutes after the conclusion of the operation consciousness began to return and soon became so complete that the patient was able to converse with her friends and was able to take food in a natural manner.

But she relapsed into drowsiness, and the next day was as comatose as before the operation. The injection was now repeated into one of the veins of the leg, into which the fluid was allowed to flow from a funnel. Under the operation which required a little chloroform, the patient's condition appeared to improve, and with this encouragement the injection was continued until increasing fullness of the superficial veins and some general appearance of congestion were taken as indications to stop; there was as yet no return to consciousness, in the hope of which, the proceeding had been continued. It was now found that no less than 350 ounces, or  $17\frac{1}{2}$  imperial pints, had passed in. This was a much larger quantity than had been intended, but the process was allowed to go on under the encouragement which the former attempt seemed to afford, and in the absence of prohibitive symptoms until the increasing congestion was thus interpreted. Three-quarters of an hour after this second injection, consciousness returned and lasted without drowsiness for nine hours, after which, she became drowsy, but was for the most part sensible; thirty hours after which there was a lapse into coma, which was final and fatal. In this case, therefore, a total of 456 ounces of saline solution were infused into one patient in the course of about twenty-four hours.

This is certainly more than the estimated average total amount of blood in the adult body and bears out thoroughly



the experimental evidence furnished by Müller, Landois and Lesser.

Finally, to conclude with the technique, I will state that the best results have been obtained in our practice with extemporized solutions of common salt (about one teaspoonful to one pint) and in view of this experience it is unnecessary to refer to the numerous and complicated formulæ that have been recommended by various authors, (*e. g.* Schmidt's, Lotta's, Colson's, Beaumetz's, Jennings's, Hayem's, Schwartz's, etc.), anything more than a neutral solution of common salt being in all probability superfluous.

We should also add that at the end of the operation the wound in the arm should be accurately closed and dressed antiseptically. By the careful observance of these rules none of the cases in our hospital practice have been followed by the least sign of phlebitis or local disturbance, the operation being so free from complications and operative sequelæ that it may be regarded as being practically innocuous.

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### HYSTERO-EPILEPSY.

By R. L. HUNT, M. D., Shreveport, La.

It is unnecessary to dwell at length upon the causation of this not uncommon disease, as it is a subject perfectly familiar to most of my confreres.

My main object in this paper is to relate in a succinct manner a case that recently came under my personal observation.

In the latter part of May, 1889, I was called to see Mrs. L., aged 23, married five years; nativity, Louisiana.

When first seen the patient presented the following symptoms: unconsciousness, clonic and tonic spasms, labored respiration, pulse weak and extremities intensely cold.

Upon inquiry I found that these attacks were quite com-

mon, always preceded by thoracic or abdominal pain, and occurring eight or nine times a month. Further investigation showed that, though they were frequent now, they did not antedate marriage, but supervened soon after.

The length of the seizures varied from half to two and a half hours, the patient upon recovery always being completely prostrated from nervous and physical exhaustion.

At the time of her marriage she weighed one hundred pounds and was in excellent health.

Soon after she began to have "fits" (as she expressed it) and when I commenced treating her she weighed only eighty pounds.

At no time had she ever been pregnant.

No sooner had the case been confided to my care, than I instituted a thorough investigation in the hope of arriving at the real cause of the disease.

Knowing that various doctors had handled her case unsuccessfully I concluded to do nothing until absolutely satisfied about a diagnosis.

Suspecting uterine trouble as the root of all the evil, especially as there was no history of heredity, etc., I insisted upon a vaginal examination.

This was granted and I found the womb anteverted, almost complete stenosis of the os, subinvolution and a chronic endometritis.

I at once proceeded to dilate the os, curette the uterine cavity and correct the displacement.

The latter I did by means of absorbent cotton plugs, saturated in a mixture of borax, alumen, iodoform, glycerine and water.

Thinking to allay any undue nervous irritability, I prescribed a judicious combination of the bromides, but soon discovered that they depressed too greatly the already weakened heart muscle.

I thought this peculiar, as the hysterical element was well marked, and can only explain it upon the ground that the general determination of blood to the pelvic organs superinduced cerebral anæmia and impaired action of the heart.

Whenever I had reason to suspect an attack, I gave stro-

phantus or some other heart stimulant and regulator, and in this way frequently aborted a seizure.

As soon as the acute symptoms of inflammation passed away a Gehrung's pessary was inserted and a vaginal douche of borax water prescribed twice daily. Every three months since then I have dilated the os by forcible dilatation, and I have persevered in this treatment for the last year and a half.

From the very first the lady improved, and from eight or nine attacks a month, I succeeded in reducing the number to seven in eight months.

During the past ten months she has only had one seizure, and that one took place six months ago.

Now she is in excellent physical condition and weighs 125 pounds.

Two remarkable facts are connected with this case: the complete recovery and the lengthy duration of the disease, with utter failure on the part of the numerous doctors to *diagnose the cause*.

She became pregnant in March, 1891, and if nothing untoward happens she will carry the fœtus to term.

## Hospital Reports and Clinical Notes.

FROM CHARITY HOSPITAL.

### LARGE FIBRO-LIPOMA.—EXCISION AND RECOVERY.

By CHAS. CHASSAIGNAC, M. D., Visiting Surgeon Charity Hospital and Instructor New Orleans Polyclinic.

John Hyatt, colored, was admitted to one of my wards July 2, 1891. He states he thinks he is 50 years old, but his apparent age is 60 or over. He is hale and hearty. He presents himself to be relieved of a tumor, illustrated in an accom-



panying cut, which is a burden in the material sense of the word, and is making his life a burden in the figurative sense. This tumor, however, is only mechanically disagreeable, as it is entirely free from pain and abnormal sensibility. It interferes with sleep because the patient can not turn easily with it, and can not get on his back at all. Various estimates are made as to its weight, ranging all the way from 20 to 50 pounds, the writer's figures being 25 to 30 pounds.

The tumor is covered by skin and by a little hair at its top where the scalp has been encroached upon by being drawn down. The skin is of normal (African) hue; its pores are enlarged by the stretching, and a few good-sized veins can be traced under it. The shape and size of the growth are not unlike those of a medium-sized watermelon. It is movable, being attached apparently to the skull from just above the occipital, protuberance downwards as far as the back of the neck by a pedicle measuring about fourteen inches in circumference. The measurement from the skull down over the upper then the under surface back to the head was twenty-nine inches, while the other circumference was about twenty-five inches.

The tumor is firm, evidently solid, and while its surface is smooth, it turns out upon palpation that it is somewhat irregular in outline beneath the skin, and chiefly so as far as density is concerned; it is comparatively soft at some points, harder at others, and very hard at some again, especially at its most dependent portion.

The tumor is carried by the old man between the shoulder-blades and causes him to assume when erect the attitude of a man holding a sack on his back or, more correctly, that of a squaw carrying a papoose on her back in a basket which is suspended from her head. It interferes somewhat with locomotion by this time although the patient was able to chop his own fire-wood up to a comparatively recent date. He first noticed a lump on the back of his head about 25 years ago, it being then nearly of the size of a hen's egg. His account of how he came to discover it is amusing. His brother's wife gave birth to a child having a wen on the back of its head, whereupon the "granny" declared that some one in the family must be the possessor of such a wen; a diligent search among the members of the family led to the discovery of the tumor on our old man. The tumor has grown steadily until now, having reached the size shown in cut, and deciding the patient to part with it.

The slow growth, the absence of pain and of tenderness, the size, the solidity, together with the irregularity of density and of subdermal outline, led me to make the diagnosis of fibro-lipoma and I decided to operate the next morning.

*Operation.*—After the tumor and its surroundings had been soaped, scrubbed, shaved and thoroughly irrigated with a 1 to 2000 solution of sublimate, the patient was anæsthetized; chloroform was first administered, then the anæsthesia was continued by means of ether so as to avoid too depressing an effect. The tumor was raised as high as we could for a few moments to empty it of blood as much as possible and an elastic band was tied around the pedicle to control the circu-



lation during the cutting, as the the tumor seemed vascular and the effects of great loss of blood on as old a man as the patient were to be dreaded. About two inches below the elastic band I made a circular incision through the skin down to the tumor itself, taking most of the flap, however, from the upper surface where the skin seemed nicer. As the tumor was finally excised, the cut vessels were quickly caught and either twisted or tied by Dr. F. W. Parham who, together with Dr. E. D. Martin and the student of the ward, Mr. Duson, ably assisted

me. The hemorrhage once controlled, the flaps were brought together vertically by interrupted silk sutures, a drainage-tube was inserted from the upper through to the lower end of the incision and an antiseptic dressing of iodoform and of bichloride gauze was applied. The old man awoke while the last stitches were being put in; he had lost comparatively little blood and scarcely suffered from shock.

After ablation, the tumor was found to weigh twenty-four pounds, and the diagnosis of fibro-lipoma was confirmed.

The patient sat up in bed the day after the operation; was out of bed the next day; never had any fever; the wound healed by first intention over the greater part of its extent; the drainage-tube was gradually withdrawn from the lower opening; at date of writing, about two weeks after the operation, he is ready to return home a happier and lighter man.

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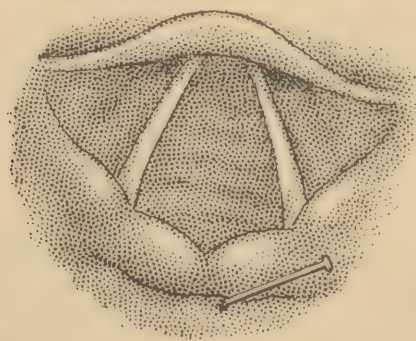
#### FROM THE EAR, EYE, NOSE AND THROAT HOSPITAL.

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##### PIN EMBEDDED IN POSTERIOR WALL OF PHARYNX. ✓

By A. McSHANE, M. D., Assistant Physician.

On July 3, 1891, Milton T., from Slidell, La., a well built young negro of twenty-eight, applied at the clinic for relief from pain caused by something that he had swallowed, and that seemed to stick in his throat. On July 1 he was eating



supper at Slidell, and while he was swallowing a piece of bread he felt a sudden and severe pain low down in his throat, as he expressed it. He had to stop eating at once. He could not eat on the following day; it was painful to drink water. On July 3 he boarded the train and came to New Orleans.



When first examined with the laryngoscope, a mass of mucus was found over the mouth of the œsophagus and covering the arytenoids. The patient said that a pin was stuck in there, somewhere. In order to examine the parts more leisurely, a solution of cocaine was sprayed into the pharynx and larynx. In the coughing and spitting following the cocaine spraying, the patient dislodged the mucus laying over the œsophagus; and when he was again examined with the laryngoscope a large pin was seen sticking out of the posterior wall of the pharynx, just above the entrance into the œsophagus as shown in the accompanying engraving. Half of the pin was embedded in the pharyngeal wall.

The part was thoroughly cocainized. In attempting to extract the pin, Mackenzie's forceps were first tried, but the pin hugged the pharyngeal wall so closely that the blade of the forceps could not be passed between them. I then resorted to Jurasz's forceps, and in a few seconds the pin was extracted, giving great and immediate relief to the patient. He returned to Slidell the same evening, and I have not yet heard of any unpleasant after-effects (abscess, etc).

I am indebted to Dr. Quitman Kohnke for the accurate drawing showing the pin *in situ*.

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## Proceedings of Societies.

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### PROCEEDINGS OF THE SHREVEPORT MEDICAL SOCIETY.

At a late regular meeting of the Shreveport Medical Society, Dr. M. C. Melansen presented a brief paper on

#### PUERPERAL ECLAMPSIA.

The essayist characterized this affection as epileptiform in its convulsive manifestations, though of very different clinical history, and as is well known, one of the most formidable that confronts the obstetrician. Its etiology is obscure. Very often without observable premonitory symptoms the attack is suddenly ushered in, increasing the difficulties of the physician, which might possibly have been obviated by a prophylactic course, had precursory signs been present.

In some instances these signs are present, notably, hemicrania, dizziness, impairment of vision, œdema of subcutaneous cellular tissue, especially of face and lower extremities, in which cases, of course, the cautious practitioner will institute preventive measures.

The question of precise pathology was as yet undetermined. On this point authorities widely differed. The essayist in common with many others was inclined to attribute puerperal spasms, primarily, to a vasor-motor disturbance caused by a disordered condition of the blood, the result of retained excrementitious matters in consequence of renal inactivity.

This diseased blood (so to speak) impresses the nervous centers and proves as it were the predisposing cause of the convulsion while the excited state of the nervous system, incident to pregnancy and parturition, acts as the exciting cause and precipitates the attack.

As regards the obstetrical management, the writer thought that while very many and perhaps the majority of authorities have taught the speedy evacuation of the uterus by instrumental means, as soon as possible after the inception of the attacks, he deemed this cause not always wisest and best, but preferred the more conservative course of non-interference in this particular direction. Thus Gooch said: "Attend to the convulsions and leave the labor to take care of itself," and says Schroeder: "Especially is no kind of obstetrical manipulation required for the safety of the mother," though he admits that it is sometimes necessary to hasten labor to insure the life of the child. The practice, however, of forcibly dilating the os uteri, turning, etc., was in the judgment of the essayist, to say the least of it, very hazardous. If on the other hand the parts were in good condition, readily admitting the application of instrumental treatment, this would be indicated and should be practised.

In respect to the general treatment, the writer did not favor the time-honored practice of indiscriminate venesection. He would resort to this (if at all) only in healthy, strong and plethoric subjects. His usual course was to administer a brisk purgative if possible, and as soon as possible, and to control the paroxysms with chloroform. By this means he had succeeded in diminishing the number and frequency of these paroxysms in severe cases, that had terminated favorably in his hands. The chloroform, he did not administer continuously, as some recommend, so as to keep the patient in a state of protracted anæsthesia, but was given whenever signs of a recurring spasm were manifest.

Chloral hydrate in combination with bromide of potas-

sium in full doses demanded favorable consideration, to which might we added morphine "in desperate cases."

#### DISCUSSION.

Dr. T. J. Allen regretted that the essayist had not said more about the etiology of this formidable but obscure affection. Puerperal eclampsia seemed to be a disease *sui generis*, about the pathology of which as yet we know nothing or but little positively. Some have regarded the kidneys as the source of the malady, while others lay the responsibility at the door of the nervous system. As to treatment, he would, in plethoric and hyperæmic cases, advise bleeding, as was practised and so strenuously urged by Dr. Meigs, Sr., of Philadelphia. Delivery as early as possible he deemed desirable. This, with anti-spasmodics and anæsthetics, such as chloroform, chloral, etc., would be the treatment he would pursue.

Dr. Randell Hunt regarded the direct cause of death to be due to asphyxia from the convulsion. In his opinion the brain was in a state of anæmia, and required stimulation. He would therefore give brandy in connection with other well known anti-spasmodic remedies. Venesection, he thought, was contra-indicated. He ventured the opinion that the pressure of the gravid uterus upon the renal veins interfered with the excretory functions of the kidneys, and thus was explained the frequent involvement of these organs in puerperal spasms.

Dr. F. E. Yoakum had found benefit in this affection from the use of large doses of *veratrum vinide*.

Dr. J. W. Allen's experience had been limited, but comparatively recently he had had a case in the country, and chanced to be unprovided with the usual anti-spasmodic agents, chloroform, etc. He therefore had recourse to antipyrine, and administered ten grains hypodermically—repeated in two hours. This treatment was followed by immediate improvement. In eight or ten hours afterward another dose of ten grains were given. The case recovered. These facts he reported as the result of an experiment, antipyrine not being usually included in the therapy of these convulsions. He regarded the matter as one, however, worthy of consideration.

Dr. H. C. Coty had had a similar experience. In his case he had given fifteen grains of antipyrine, repeating the dose in an hour and a half, making thirty grains in all, with most beneficial results.

Dr. A. A. Lyon arose simply to say, that the treatment as now generally resorted to, viz: chloroform, chloral and remedies of that class in puerperal eclampsia, were orthodox and clearly indicated as it appeared to him. He was moreover strongly inclined to think that the premature and forcible



evacuation of the uterus was not only not demanded but positively injurious, and that he thought there was a growing sentiment in the profession looking in this direction. The foetus, probably, bore no important part indirectly producing the convulsions as would seem to be indicated by the fact that in a very large percentage of cases the convulsive phenomena did not appear till after delivery was completed. He would therefore advise a tentative and conservative course rather than have the radical measures so often recommended and practised. If the use of forceps is possible without violence, the delivery should of course be hastened by this means. A. A. L.

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GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF  
BALTIMORE.

MAY MEETING.

The President, Dr. Henry M. Wilson, in the chair.

Dr. Brinton read a paper entitled "A Day's Work in Obstetrics." Under this title he related the following cases:

1. A case of podalic version.
2. A case of normal labor.
3. A case of shoulder presentation; efforts at version unsuccessful; vagina ruptured; the woman dying undelivered.
4. A case of placenta previa lateralis treated by internal podalic version. Mother and child saved.

Dr. Miltenberger—There is some discussion in regard to the preference for high forceps and version. I prefer version, but the profession is divided and the choice comes to a matter of skill and individual practice.

Dr. Neale—One of the points claimed for version over high forceps is that in version the narrow diameters of the head come first. It has been claimed that the same condition is brought about in the use of forceps by the diminution of the diameters of the crown, so that they are less than those of the base of the skull. I can not see how this is, for certainly the forceps do not, as a rule, compress sufficiently to reduce the diameters of the crown to less than those of the base of the head.

Repeated attempts at version often give bad results when the uterus is contracted and retracted, and when there is a neglected cross-birth and the child is dead. After a moderate attempt at version has failed, decapitation should be done.

By means of Braun's hook it is certainly a comparatively easy and safe procedure.

I have no criticisms to make upon the treatment Dr. Brinton adopted in his cases.

Dr. Brinton—Since this case of rupture of the vagina has been reported it has been stated by a pathologist of this city that it is the only one on record. I would like to ask if any of the gentlemen present know of any such cases?

Dr. Miltenberger—There are certainly on record many cases of rupture of the vagina. I have seen at least two such cases.

Dr. Thos. A. Ashby—I once passed a sound through the uterus. The sound went in easily, and could be felt just below the umbilicus. Before this the patient had had pus running slowly from the uterus which had evidently had its origin higher up. There were no bad symptoms; the woman rode home a distance of eight miles and was not heard from.

I once attempted to remove an epithelial growth from the vagina and all at once the intestines came down. I cleaned away the diseased tissue, closed up the opening with a firm stitch and the wound healed promptly. The patient lived eleven months.

Dr. Geo. W. Miltenberger read a paper upon "Superfoetation and Superfecundation."

Dr. P. C. Williams—I had a case recently of ovulation during lactation. A lady came to me who had contrived to nurse her child and is now five months pregnant. These cases show that there may be ovulation without menstruation, and are we to agree with Dr. Miltenberger.

Dr. Ashby—I have had cases similar to Dr. Williams. I have been surprised at the frequency with which menstruation returned after apparent removal of both ovaries and tubes. One of the first cases upon which I operated, was one of hystero-epilepsy. I thought I had removed all the ovarian tissue, but found subsequently that I had not. She began to menstruate about eight months after the operation, and afterwards suffered from metrorrhagia. Three years later I examined her under chloroform and found a small tumor. I operated and removed a small portion of an emptied ovary. She recovered promptly and has not menstruated. Her health is good and there has been no return of the hystero-epilepsy. I have had other cases in which some parts of the ovaries had been left behind. These women continued to menstruate. In those cases where I have succeeded in removing the ovaries entirely, I have not observed the return of menstruation.

Dr. B. B. Browne—I attended a woman a few years ago who had had seven children and had never menstruated. She was married before menstruation began, and had had children

very frequently. I think superfœtation does occur. It certainly occurs in uterus septus.

The removal of the ovaries has little to do with the cessation of menstruation, but the tubes have much to do with it, and it is when a portion of the tube remains behind that menstruation continues. Metrorrhagia will occur when the tube is closed at the outer extremity. When a part of the ovary is left, of course a part of the tube is left also.

Dr. W. E. Masely—My experience has been such as to make me believe that menstruation does not depend upon the presence of the fallopian tubes, nor is it independent of the ovaries. Eighteen months ago I opened a lady's abdomen for a very severe case of uronic pelvic peritonitis with double pyosalpin. Both tubes were tied close to the uterus and removed, but after a diligent search no trace of either ovary could be found. Dr. W. H. Welch, to whom the specimens were shown, expressed the opinion that the ovaries had probably been destroyed in the inflammatory process. The patient made a good recovery after very prolonged drainage, made necessary by the sloughy condition of the pelvic contents and the fecal fistula, which persisted for several weeks. This patient for months has been menstruating regularly and freely every three weeks. In all probability some portion of ovarian tissue escaped destruction.

In another case in which I took special pains to remove every particle of each ovary and both tubes on account of severe hemorrhage, the patient has not had a show during the past twelve months.

Dr. Ashby—Mr. Tait has maintained the position of Dr. Browne for several years.

In one case the patient had been suffering from hemorrhage of tubal origin. I removed both tubes and one ovary. The other ovary having undergone cystic degeneration, it was impossible to remove all the ovarian tissue. This patient has been cured of her metrorrhagia, but has a normal menstruation.

Dr. Opie—It seems quite well established by post-mortem results that all cases of menstruation, following oöphorectomy, are not due to failure on the part of the surgeon to completely remove the ovaries.

The inter-ovarian ligament, however, is sometimes very short and the button-like section beyond the ligature which in such cases contains ovarian stroma, may keep up a dominating influence; again the anatomical shape of the ovary gradually sloping off into the ligament, causes a part of the ovarian tissue to be left on the uterine side of the ligature in spite of the utmost care on the part of the operator.



The rule after child-birth seems to be that menstruation is in abeyance for a variable number of months, but cases have doubtless occurred in the experience of most obstetricians, when it has been uninterrupted during lactation. I have met with a number of cases when women have conceived during lactation, when there was no accompanying monthly flow. Dr. Tait thinks that during and even after the menopause ovulation goes on, though the mucous membrane is disqualified for securing a fecundated ovule. Ovulation may be going on during lactation, but the mucous lining of the uterus may not be well qualified for menstruation or fecundation.

Dr. Bush, of New York, who has a dairy farm has been performing some interesting experiments to find out the mode of securing the best quality of milk. He has determined that the heifer after the removal of the ovaries can be made a perpetual milker and that the milk is of better quality than in cows subject to ovulation and impregnation.

Dr. Brinton—With reference to menstruation after the removal of the ovaries, we have the statement that 1 or 2 per cent. of women have supernumerary ovaries, and possibly the return of the menstruation is due to the presence of the third ovary.

Dr. Miltenberger—Dr. Browne laid much stress upon the fact that menstruation continued when obstructed tubes were present. Menstruation has nothing to do with the passage of the ovule along the tubes, but is due to the maturation of the ovule. Therefore, the tube may be obstructed as much as you please and there will be no results. Battey and Engleman have reported a number of cases of pregnancy after the ovaries were apparently removed by skilful operators. In other cases the ovaries, supposed to be removed, have been found post-mortem.

Dr. Browne—In most cases where the ovary and tubes are removed the lumen of the tube is obstructed by the ligation.

Dr. Ashby—Exhibited a specimen of a ruptured tubal pregnancy which he had removed from a patient seen in consultation with Dr. Arthur Williams, of Elk Ridge, Md. The patient was 34 years of age and gave birth to one child ten years ago. She conceived, in February of this year, and about the eighth week of gestation, was seized with violent symptoms of intrapelvic hæmatocele. Dr. Williams was called in and after examination diagnosed the condition as a ruptured tubal pregnancy. I saw the patient with him the following day and, upon examination, confirmed the diagnosis. The patient rallied from the shock of the first rupture, and one week later

a second rupture took place, though not followed with such violent and dangerous symptoms as in the first instance. The surroundings of the patient were so unfavorable that she was removed from her home in Anne Arundel county to the Maryland General Hospital, where the laparotomy was performed. Upon opening the abdomen her pelvis was filled with bloody serum, blood clots and evidences of general peritonitis. The omentum was in such a condition that it was found necessary to remove about three-quarters of the tissue.

The patient was critically ill, from the third to the fifth day, from symptoms of intestinal obstruction.

Her bowels were moved by administering one grain doses of calomel every hour for twelve hours, every other method having failed. The patient has made a successful recovery.

This is the third case of tubal pregnancy I have removed by laparotomy within the past two years, all of them having recovered.

WILLIAM S. GARDNER, M. D., *Secretary*.

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LETTER TO THE FLORIDA MEDICAL ASSOCIATION, IN SESSION AT PENSACOLA, FLA., APRIL 14-16.

By R. B. S. HARGIS, M. D.

*President and Gentlemen of the Florida Medical Association:* It is in consequence of a painful indisposition that I have to deplore my inability to meet you and participate in your proceedings during the present session. That you have been duly welcomed to our city and to this hall with becoming honors, does not forbid me the pleasurable duty, as a member of your association, to extend you a kindly greeting and cordial welcome to the hospitalities of our city, and extend the right hand of fellowship due you on the occasion.

Many of you are aware that I for many years have cherished a profound interest in the advancement of the medical sciences and manifested my devotion to the profession by frequent contributions to the medical literature, a few of which were first presented to the profession through your published transactions.

It was my intention to respond promptly to the official notification of the secretary, and present a paper to the association at this meeting, but, unhappily, an engraftment of a severe "grippe" upon my chronic infirmity prevented me. I hope, however, that a kind Providence will vouchsafe to me sufficient health and strength to finish one I have in hand and present it to you ere long through another channel or at your next meeting.

Gentlemen, this noble organization, the Florida Medical Association, has been to me an object of deep and abiding interest and a prolific source of valuable knowledge, and I do most heartily congratulate you on the varied and important successes that have crowned your noble efforts to advance the medical sciences, and effect means to improve the physical condition of the people. Since its organization it has been so conducted as to give a united and emphatic expression to the views and aims of the medical profession throughout the State; and the professional mind in other States has been at no time more active, and although their means and aids from intelligent and influential outside influences have been infinitely greater the results have not been of larger utility or intrinsic value.

This association must, at all times, exercise a beneficial influence, and supply a more efficient means than have hitherto been available in our State, for cultivating and advancing medical knowledge, for elevating the standard of medical education, and promoting the usefulness, honor and interests of the medical profession; and while it enlightens and directs public opinions in regard to the duties, responsibilities and requirements of medical men, it excites and encourages emulation and concert of action in the profession, and facilitates and fosters friendly intercourse between those engaged in it.

The transactions of your last meeting at Ocala, as indicated in your published proceedings of that session promises much for the future. On reviewing it carefully with a view to examine it critically, I was deeply impressed with the precise parliamentary order of proceedings, but the work of the associations as manifested in the various papers read before it on that occasion clearly indicated that, alive to medical progress and to the interests of the State and of humanity it aspires to the conservation and perfection of the good and true of our noble profession.

The different papers bear the marks of judicious and appropriate selections of subjects and painstaking in their preparation. Taken separately or as a whole, these papers would do credit to any medical organization in this or any other country. Your proceedings should be more widely circulated amongst the people, that they may behold the results of your labors. Your "light should not be hidden under a bushel." Many, however, of intelligence and influence have borne witness to the good practical results already manifested, and fully appreciate their inestimable value. The establishment of the present Board of Medical Examiners, which has already shown itself to be a powerful protective means of rescuing the people from



the hands of unscrupulous quacks. The establishment of our State Board of Health is due to the influence of the Florida Medical Association, and the institution and practical application of sanitary measures, involving many valuable suggestions relating to quarantine, are due to its influence. The Florida Medical Association is an authority on State medicine, and should be widely known as such. I am not giving utterance to words suggested by a spirit of vain adulation or obsequious patronage. I speak the language of *truth, verum atque deus*. Ours, gentlemen, in the words of the immortal Stokes, "is a noble profession; the only one relating to earth-born things which, while it ennobles the mind of man, softens and expands his heart, whose end is good to man. It is these god-like qualities of our profession that stimulates its votaries in the pursuit of truth and the practise of benevolence. The only enemies we combat are error and disease. In assiduously cultivating the powers of discovering truth and the desire of applying it for the promotion of human happiness, we have the great end and object of our existence. In our contest, then, with error and disease we enter into to no compromise with evil, and the good we do to our fellow creatures never involves injustice to another."

The life of the medical practitioner is one of ceaseless battle not in combating disease, but to counteract the life-invading influences that men put in action. Against Nature's law we do not presume to contend, "all that is born must die." But medicine has clearly enough shown that at least three-fourth of those who perish, succumb to causes more or less due to the carelessness or ignorance of man; visit that hospital not far off, enter its wards, there you will first see a patient sick with fever or consumption, a victim to foul air emanating from the sewage or some filthy excavation, or lake sodden soil reeking with decomposing organic matter or engendered in his cramped and overshadowed dwelling, never purified by the living atmosphere or the rays of the sun. The next is one whose limbs are fractured, or who has sustained some other injury, which benevolence directed by science might have averted. Further on is another one whose energies are destroyed and spirit broken, whose body is diseased, whose mind is debarred by indulgence in those "accursed drinks where use is abuse, whose purity is foulness, to adulterate is a superfluous or positive fraud."

These are but very few of the evils we have to combat in civil life. For this we never relax our efforts to acquire increased knowledge. The fascination which Nature exercises over the disciples of the healing art explains much in the con-

duct of the practitioner of medicine in which is either incomprehensible to the public or often misconstrued. The common incentive to labor among the people generally is the love of gain; the intermediate motive to exertion is money. It is very true that they may be a stimulus in the love of action. Slothfulness to most men is intolerable. Some kind of exercise for the muscles and the brain is necessary to the meanest enjoyment of life. But we may safely affirm that the truth of the maxim *Labor ipse voluptas* is by no means so thoroughly appreciated as by the physician. In the exercise of his vocation, he not only exults in the sense of healthy and honorable exertion, but he is gratified by the consciousness that he is extending acquisitions and enlarging the powers of the intellect; he feels not only the pride of new conquests, but the ever new excitement of expectation.

Medicine is essentially a progressive science. It is progressive as an abstract branch of knowledge; it is progressive as regards every individual who follows it as a profession—the physician is always and above all a student. Deprive him of the means of observing disease and you render him unhappy. Not because he is enamored with pus, miasm and microbes, still less the sight of human agony has any attraction; not because the employment is profitable in a pecuniary sense; he is unhappy because he feels that without the opportunity of observation the knowledge he possesses will decay, the faculties which are strengthened by exercise will be lost. With all his industry and zeal the physician may not find wealth but he surely will find happiness and competency. If, indeed, we do have few splendid prizes, if there be but few great fortunes amongst us, so there are but few reverses. It is one of the immunities we enjoy to a large extent with the other learned professions, that we are tolerably secure from those calamities which the errors and misfortunes of others so often entail upon those engaged in commerce and speculation. There is, perhaps, hardly any profession in which a man need depend so little for success upon extraneous aid. So long as he enjoys the blessing which is his aim to dispense to others, the physician approaches most nearly to the Horatian standard of freedom and independence, the man "*ipse totus atque rotundus*."

This you may say is the bright side of the question. It has, no doubt, a reverse one—a side not without asperities and shadows; upon this, however, I think it unmanly and unbecoming to dwell. "Success rarely attends the garrulous man." We'll all, no doubt, have our difficulties and disappointments, our days of expectation, our hours of despondency.

In all this I, *more* than most men, can sympathize. But unalloyed prosperity is not the lot of man, nor indeed is it good for man. The true use of present adversity is to chasten and strengthen the mind for new struggles, to teach us to look hopefully into the future, not alone of this life but of the "life beyond the grave."

I can not forbear to repeat in conclusion, as a sort of summary of the text, what I said on a former occasion: The object of our Association is to further the interests of our great profession and of humanity. It is well to keep a high standard of excellence in view, and it is to be hoped that the link shown to exist between the medical minds of the seventeenth, eighteenth and nineteenth centuries and leading inventions of the eighteenth and nineteenth may inspire all to hope for solid advances in sciences by increasing devotion and observation on the part even of overworked practitioners. Medicine has proved itself resplendent in the past. Let each and all of us not *dim* the *lens* which, converging the rays of the past, almost threatens to blind us. We have but one course to pursue and that is *onward!*

Faithfully yours,

R. B. S. HARGIS, M. D.

109 East Romana St., Pensacola, Fla.

#### AMERICAN DERMATOLOGICAL ASSOCIATION.

Programme of the Fifteenth Annual Meeting, to be held at the Shoreham Hotel, Washington, D. C., September 22, 23, 24 and 25, 1891.

Officers for 1891—President, F. B. Greenough, M. D., of Boston; vice president, L. N. Denslow, M. D., of St. Paul; secretary and treasurer, George Thomas Jackson, M. D., of New York.

#### FIRST DAY—SEPTEMBER 22, 1891.

Business meeting (*with closed doors*) at 9:30 A. M.; report of council; nomination of officers for the ensuing year; appointment of auditing committee; proposals for active and honorary membership; miscellaneous business.

Morning session at 10:30 o'clock. Report of Committee on Nomenclature, and discussion thereon.

Papers—Dermatitis Hæmostatica, Dr. H. G. Klotz; a Case of Lupus Erythematosus with Fatal Complications, Dr. W. A. Hardaway; Report of a Case of Universal Erythema Multiform, with colored portrait and specimen, Dr. L. A. Duhring; An Unusual Case of Sarcoma, involving the Skin of the Arm; Am



putation; Recovery, Dr. F. J. Shepherd; Multiple Sarcomata, History of a Case Showing Modification and Amelioration of Symptoms with large doses of Arsenic, Dr. S. Sherwell.

SECOND DAY—SEPTEMBER 23, 1891.

Business meeting (*with closed doors*) at 9:30 A. M. Report of Treasurer and Auditing Committee; election of officers; election of active and honorary members; selection of time and place of next meeting; miscellaneous business.

Morning session at 10:30 o'clock. Report of Committee on Statistics.

Papers—Discussion on Tuberculosis of the Skin: Its Clinical Aspects and Relations, Dr. J. C. White; Its Pathology, Dr. J. T. Bowen; Its Treatment, Dr. G. H. Fox; Thirteen Cases of Tuberculosis of the Skin, with their treatment, Dr. J. S. Howe: A Case of Lichen Scrofulosorum, Dr. J. Grindon; Notes of a Visit to the Leper Hospital at San Remo, Italy, with photographs, Dr. L. A. Duhring.

THIRD DAY—SEPTEMBER 24, 1891.

Morning session at 9:30 o'clock.

Papers—The Treatment of Alopecia Areata, Dr. P. A. Morrow; A Therapeutic Note on Alopecia Areata, Dr. L. D. Bulkley; Morphia Atrophica of Wilson, Dr. R. W. Taylor; The Treatment of Pruritus, Dr. E. B. Bronson; Prairie Itch, Dr. L. N. Denslow; Diseases of the Skin Associated with Derangements of the Nervous System, Dr. W. T. Corlett; Treatment of Chronic Ringworm in an Institution for Boys, Dr. L. A. Duhring.

FOURTH DAY—SEPTEMBER 25, 1891.

Morning session at 9:30 o'clock.

Papers—Notes of a Case of Acute Dermatitis Exfoliativa, Dr. J. E. Graham; Note Relative to Pemphigus Vegetans, Dr. J. N. Hyde; A Study of Mycosis Fungoides with Report of a Case, Drs. H. W. Stelwagon and H. Leffingwell Hatch; Lymphangioma Circumscriptum with Report of a Case, Dr. M. B. Hartzell; Remarks on Carbuncle with Report of a Peculia Case, Dr. H. G. Klotz; Note on Erythema et Naevus Nuchae, Dr. C. W. Allen; A Case of Lichen Ruber, Dr. J. Grindon; The Personal Equation in Dermatology, Dr. L. D. Bulkley; The Hypodermic Use of Hydrargyrum Formamidatum in Syphilis, Dr. R. B. Morison; Retarded Hereditary Syphilis, Dr. R. B. Morison; Epilation, Its Range of Usefulness as a Dermato-Therapeutic Measure, Dr. J. Zeisler.

Retirement of old officers and induction of those newly elected.

Adjournment.

PHILADELPHIA COUNTY MEDICAL SOCIETY, APRIL 22, 1891

ON THE ANTI-MALARIAL PROPERTIES OF PAMBOTANO  
(CALLIANDRA HOUSTONI).

By A. E. ROUSSEL, M. D., Demonstrator of Physical Diagnosis in the Medico-Chirurgical College; Physician to the Howard Hospital; to the Southwestern Hospital, Etc.

I take pleasure in bringing to your notice a drug which has recently been the subject of considerable experimentation as regards its anti-malarial properties, but which has not yet been tested, so far as I know, in our own country.

The pambotano, or *calliandra houstoni* (Baillon), is a small tree, growing from three to five feet high, and is found principally in Mexico, where it seems to have possessed considerable reputation for its medicinal qualities.

It was first prominently brought before the attention of the medical profession through an article of Dr. J. Valude, which was presented to the "Académie de Médecine" of Paris by Dr. Le Roy de Mericourt, on the 19th of November, 1889, and which resulted in a report on the subject by the "Académie" on February 18, 1890.

In this report Dr. Dujardin-Beaumetz, although doubting the ability of this drug to replace quinine, admits of its apparent value, and suggests the necessity for further experiments in this direction. Dr. Villejean, in a chemical analysis of the plant, has as yet been unable to isolate its active principle, but notes the presence of a peculiar tannin, which yields a dark-green precipitate with the perchloride of iron, and thus closely resembles the tannin of catechu and cinchona.

Dr. Valude uses a decoction and alcoholic elixir in doses of 70 grammes for an adult, and 35 grammes for a child under 12 years of age. One litre of this solution should be divided into four doses, and taken within the twenty-four hours, each dose to be sweetened and drunk hot. His report comprises personal observations of fifteen cases of malarial fever, besides a *résumé* of the results obtained in Mexico, Japan and Italy. Of the fifteen cases in question seven were complicated by other diseases, such as la grippe, tuberculosis, grave anæmia, and in one case by intermittent dental neuralgia. In the last cases the periodical attacks were suppressed, while the results in the uncomplicated cases were uniformly successful, and in the majority of instances but one dose of pambotano was necessary to effect a cure.

The following observations are related in detail:

CASE I.—Girl of 16 years; very anæmic, quotidian fever beginning May 17, 1886, at 2 o'clock, and becoming permanent with exacerbation the following day at 2 o'clock. Con

tinual headache, which increases at time of access. Decoction of pambotano May 22. Vomiting at the second dose. Nausea with first dose. Cephalalgia disappears after first dose. Since that time the fever has not returned.

CASE II.—Child of 12 years; same type as above, with violent cephalalgia, which is worse at the beginning of fever, 4 and 5 o'clock in the evening. Decoction of pambotano the fourth day of the fever. Nausea and vomiting after first dose. At third dose child vomited food taken one hour before, but no medicine. Food taken twenty minutes after the last dose was followed neither by nausea nor vomiting. The bowels were opened after the first two doses. The headache disappeared after the first. At 4 o'clock fever did not return. Two doses alone had been absorbed. The cure was definite.

CASE III.—Man of 22 years, suffering from intermittent fever contracted at Tonking. Four different attacks while at Tonking at two or three months interval (in September, December, February, April). Returned to France in May. Return of fever in July, tertian type. Decoction of pambotano the day of the attack. Some nausea, no vomiting. After the first dose the headache disappeared. The fever did not return. Fifteen months afterward the cure was maintained, and the fever which had previously returned every two months had not reappeared.

CASE IV.—Man of 44 years. Subject to the tertian fever, two attacks of which have been treated by quinine. At the third attack decoction of pambotano. Some nausea. The fever has not returned.

CASE V.—Woman, 48 years of age; quotidian type, commencing at noon with a violent pain on the right side. The elixir, containing fifty grammes of the root, was given on the 30th of March. Some nausea. One passage after the first dose, which caused the disappearance of the pain above mentioned. At 1 o'clock the customary chill did not appear, but a slight elevation of temperature was noticed. On the 31st of March the fever returned to a slight extent. On the 2d of April no fever, but the appetite was poor and the tongue coated. After the 3d of April the fever no longer returned.

CASE VI.—Man 46 years of age. First attack. Suffering for eight days from well-marked attacks, with violent cephalalgia. Decoction of seventy grammes of pambotano. No bad results. At noon, the customary hour for the chill, nothing was noticed, notwithstanding that only two doses had been taken.

The following cases have also been collected by Dr. Valude:

Dr. J. M. Bandera, of the University of Mexico, after



carefully testing the drug in various hospitals, declares that he has obtained excellent results, even in cases which have not yielded to the use of quinine.

Professor J. D. Campuzano, of Tacubaya, as well as Dr. J. B. Lobato, report excellent results.

The government of Guanajuato appointed Drs. J. Hernandez, R. Lopez, and T. Dominguez to report officially on the merits of pambotano, and after careful experiments these gentlemen reported marked success.

Dr. Lafont reports having treated the conseiller-general of French Guiana, who had suffered from a severe type of malarial fever for five years, which had resisted the use of quinine, arsenic, as well as a long sojourn at Vichy. One dose of pambotano was sufficient to effect a cure, which is maintained until the present time.

In the province of Salto, Argentine Republic, Drs. C. Cotas, J. Tedin, and A. Valdez have treated numerous cases of malarial fevers, some of which were uninfluenced by the administration of quinine, but all of which yielded to the use of pambotano.

Concerning the results obtained by its use in the French and German hospitals at Yokohama, Japan, the Belgian minister reports that in all cases a cure resulted within forty-eight hours.

Dr. A. de Cadilhac, an Italian physician, reports the cure of a case of obstinate malarial fever contracted in the neighborhood of Rome, which has resisted the use of strong doses of quinine.

Dr. Betances, now of Paris, reports three cases of severe malarial fever, contracted at Panama by employés of the Canal Company, which had totally resisted large doses of quinine and arsenic, as well as the douche treatment. In each case one dose of pambotano resulted in a permanent cure.

Dr. Depeton, practising in the Basses Pyrénées, gives a history of three cases, with an equally successful termination.

Dr. De Chapelle, of Bordeaux, reports a case of quotidian intermittent, in a patient seventy-two years of age, where quinine at first yielded good results, but afterward lost its effect. The patient was in a desperate state when he was placed upon one day's treatment of pambotano, which resulted in a total cure.

Since the collection and publication of these statistics numerous cures have been reported by physicians in different parts of France. The results, as reported, are so uniformly successful that the question arises whether a certain allowance should not be made for the enthusiasm which so generally attends the introduction of a new remedy.

Still more recently (*La Tribune Médicale*, April 30, 1891) Dr. J. Pelletan reports the case of a man, 38 years of age, who contracted repeated attacks of malarial fever of divers types while living in various parts of South America. Returning to Paris some years since the fever reluctantly yielded to the quinine treatment, but was followed by obstinate neuralgias in various parts of the body, and particularly by an atrocious sciatica, which caused the most intense suffering.

Notwithstanding the most varied forms of treatment, nothing afforded even temporary relief, except hypodermics of morphia.

The patient at this time was marked by emaciated complexion of a pasty yellow, with a parchment-like skin, cachetic appearance, and the spleen was markedly enlarged. No history of syphilis or alcoholism.

On the 19th of January last he was ordered a dose of pambotano (Midy).

Up to the present time (April 20) he has been entirely free from all pain, notwithstanding that he was exposed to the inclement weather of a Paris winter.

My own observations are limited to eight in number as far as the malarial fevers are concerned. Each of the above cases, however, was carefully observed for a varying period of time before the administration of the medicament in order to insure accuracy of diagnosis. I have also observed its results in other diseases, such as la grippe, typhoid fever, phthisis, etc., but, frankly speaking, no influence could be detected upon the course of these different maladies.

The preparation used in these cases was an alcoholic elixir prepared by Midy, of Paris, and kindly furnished me for the purpose by Rigaud and Chapoteaut. Each bottle of the elixir contains 90 grammes, representing 70 grammes of pambotano. The contents of each bottle is to be administered in four equal portions within the twenty-four hours in hot sweetened water or tea, and preferably taken on an empty stomach.

The cases are as follows:

CASE I.—A clergyman, 40 years of age, contracted a quotidian intermitent while on a gunning trip in Virginia, six years ago. Since that time, he has, without exception, been subject to a renewal of the attacks every spring, and occasionally in the fall of the year. These attacks yield to treatment of large doses of quinine and arsenic, but generally incapacitate him from work for a period of about two weeks. His present attack commenced with a chill on March 2, 1891, at 4 o'clock in the afternoon, followed by a temperature of 104 deg., and a return of the same symptoms on the succeeding

day. He commenced taking the elixir of pambotano on the 4th of March, but experienced a modified chill on the afternoon of the same day; temperature 102 deg. Some nausea after the first dose. Since that time he has had no return of the above symptoms.

CASE II.—Girl, aged 17 years, employed in a mill, residing in the southern section of the city, presented herself at the Southwestern Dispensary, with the history of having had a chill on the previous day followed by fever and sweating. Temperature at the present time normal, but patient feels weak and languid; tongue coated. She was directed to return the next day. On this occasion the thermometer marked 102½ deg. She commenced the pambotano the same afternoon, taking two doses on that day, and two the day following. The first dose was vomited within fifteen minutes, but the subsequent doses were retained. She remained under further observation for ten days, with no return of the fever.

CASE III.—Woman, aged 37 years, dressmaker; has had attacks of quotidian intermittent in the spring of the year for the last four years, which kept her confined to the house for about ten days on each occasion. Was taken with a chill March 24, followed by the regular symptoms, which were again repeated the next day. Commenced the use of pambotano March 26. Some nausea after each dose, but no vomiting. Bowels opened three times during the course of the day. Resumed her occupation on the 27th, and subsequently reports (June 8, 1891) that she has been entirely well ever since.

CASE IV.—Commercial traveller, aged 25 years. While in Florida last autumn he was taken ill with a severe type of remittent fever, which confined him to the hotel for a period of seven weeks, and which finally yielded to large doses of quinine and arsenic. Present attack commenced April 3 with chill, fever, intense headache, coated tongue, nausea and some vomiting. Commenced the pambotano on April 4; the patient vomited the second, third and fourth doses. On evening of same day he was given three grains of calomel in divided doses, to be followed by a saline. On the morning of the 5th, the fever still being present, the drug was ordered continued as on the previous day, but he again vomited the first and third doses, besides which the bowels were opened at least a dozen times. On the 6th the patient appearing no better, and the irritability of the stomach still being present, he was placed on suppositories of quinine, together with the use of Fowler's solution internally. After further treatment of about a week, the patient entered into a rather slow convalescence.



CASE V.—A woman of 35 years, with a distinct malarial history, had been under my care for over a year suffering from severe attacks of neuralgia in various parts of the body, but particularly of the facial type. Rarely a week passed without severe suffering on her part. Quinine, arsenic, antipyrine, and the general routine treatment, including electricity, had been used without any permanent result; the same may be said of the extraction of several decayed teeth. Commenced taking pambotano on April 6 without suffering any inconvenience from the drug. The pains disappeared to a great extent until April 18, when she experienced another attack, but milder in character, according to her testimony. Another dose of pambotano was administered April 19, since which time she has been free from pain, with the exception of slight twinges occurring in damp weather.

CASE VI.—Laborer, aged 40 years, applied at my service at the Howard Hospital, May 2, 1891, with a tertian intermittent, the result of an attack contracted four years ago, and which has since visited him every spring and fall. Commenced pambotano the next day, since which time the fever has not returned.

CASE VII.—Laborer, aged 35 years, applied at the Howard Hospital, May 22, with a tertian intermittent, which, he thinks, he contracted while digging at Greenwich Point. Some irritability of the stomach being manifested, small doses of calomel were ordered for that day. Commenced pambotano on the 23d, but vomited the third dose. Slight chill on morning of the 24th. Drug continued during the day, after which no further treatment was necessary.

CASE VIII.—Laborer, aged 32 years, applied at the Howard Hospital June 2 with quotidian type of fever, headache, vomiting and diarrhœa. Commenced pambotano June 3, but vomited each and every dose. Drug continued June 4, and only the last dose was vomited, but the number of intestinal movements were greatly increased and accompanied by some griping pain. The fever not being apparently influenced, he was placed under large doses of quinine, and is now entering convalescence.

As will be seen by the above, my results, although decidedly encouraging, are hardly as satisfactory as some of the reports from abroad. In the two cases where the exhibition of the drug remained apparently without result, the question may arise as to whether a sufficiently large quantity was really absorbed on account of the gastro-intestinal irritability. Indeed, this undesirable feature seems to play a more or less important part in most of the cases.

For the above reason it would seem especially desirable

that an active principle should be isolated. And we can only wonder that this has not already been accomplished in a drug whose action seems to be sufficiently pronounced to obtain results within such a comparatively short period of time.

In conclusion, it would seem to me that the results already obtained are sufficient for further work in this direction, especially as no opportunities for observing malarial fevers are better than those of the French physicians.

#### DISCUSSION.

Dr. James Collins—In our reports on malaria we are apt to lose sight of the fact that we have two distinct kinds of malaria, one the malaria of swamps and the other the malaria of great cities. This drug seems to have been used principally in the malaria of cities, and the results seem analogous to those of a remedy which we have in our country, the *eupatorium perfoliatum*. The paper read to-night is so much like a paper I heard read some fifteen or twenty years ago, on the drug mentioned, that I could not refrain from mentioning it.

Dr. Thomas J. Mays—This drug is entirely new to me, but it seems that it does not act like quinine. From the reports which we have presented to us here it appears that at least a part of its action is confined to the gastro-intestinal canal, stimulating the biliary secretion, etc. We know of many agents which antagonize malaria by acting in this way. Chloride of ammonium, calomel, *hydrastis Canadensis* are given, and have an excellent influence on malaria, and I think chiefly because they act upon the liver. Quinine is a remedy which stands by itself, and I was in hopes that in this agent we would find a prominent rival to it, but it seems not. I trust that Dr. Roussel will continue his researches into the the remedy which seems to hold out such promising results.

Dr. Roussel—In reply to Dr. Collins, I would state that while my observations were made on malaria as it occurs in large cities, the studies of the foreign observers, especially those in Mexico and Italy, were on the so-called "swamp fever" of a rather intense type.

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### ALLEGHENY COUNTY MEDICAL SOCIETY.

MEETING OF JUNE 16, 1891.

#### VOMITING OF PREGNANCY; ITS ETIOLOGY AND TREATMENT.

By F. BLUME, M. D., Allegheny, Pa.

Pregnancy, as a rule, is complicated with a variety of disorders, which, though in many instances causing much discom-

fort, are termed physiological as long as they are not associated with serious disturbances of the organism. Derangements of the gastro-intestinal canal, nausea and vomiting, to the consideration of which I invite your attention to-night, are such a regular occurrence during the early period of pregnancy, that experienced women consider them as positive signs of conception.

The so-called morning sickness—nausea and vomiting early in the morning, or even after meals during the first few months of gestation—have, in the large majority of cases, no effect either upon the course of pregnancy or upon the health of women. Although the ordinary morning sickness sometimes persists during the whole period of pregnancy, it remains endurable, causing the patient rather annoyance than injury. There are intermissions, either spontaneously or the consequence of some treatment, the digestive functions remain more or less normal, and the vitality of the patient is not essentially impaired. In some, fortunately very rare instances, however, nausea and vomiting become incessant and uncontrollable, the stomach rejects everything, the patient grows weaker till the most extreme degree of exhaustion is reached, and death from starvation threatens.

The onset of this grave form of the affection is gradual, and does not differ in character from the usual morning-sickness. But soon the nausea becomes more intense, the vomiting more frequent. The ejected matter consists of food, mucus and bile. The appetite is more or less impaired or perverted; the thirst is excessive; constipation is more frequent than diarrhœa; the urine is scanty, concentrated and contains albumen and casts. The pulse grows small and rapid, the temperature rises and continued fever develops.

With the progress of the disease the condition of the patient becomes more and more alarming. The nausea is almost constant, adding greatly to the discomfort of the woman. The efforts at vomiting are accompanied by violent retching and pain, not the smallest amount of food or drink is retained by the rebellious stomach, the smell, even the thought of nourishment, or the slightest movement of the patient, induces an attack. The vomited matter is finally mixed with blood. The thirst is tormenting, the throat and mouth are dry, the tongue brownish, the breath fetid, the abdomen tympanitic. The consequences of this continued suffering soon become very pronounced by the marked alteration of the features, the extreme emaciation and the profound depression of the patient. Shortly before life ends vomiting ceases and coma supervenes.



Cases of persistent vomiting, which terminate fatally, are certainly very rare. Even after the application of various methods of treatment has failed to influence the course of the disease, and while the induction of abortion was earnestly considered, the patients have recovered spontaneously and have gone to full term, as I have seen in the only instance of this grave disorder which has come under my observation.

There is considerable diversity of opinion as to the causes which may incite hyperemesis, and, in spite of numerous theories and hypotheses, the etiology of this disorder is by no means clear. It is almost universally accepted to be a reflex neurosis originating in the uterus and dependent either upon pregnancy alone or upon co-existent pathological conditions.

Pregnancy itself, the growing ovum, which acts as an irritant by the simple mechanical distension of the uterine cavity and its peritoneal covering, is in the first place to be mentioned as the most potent etiological factor.

Cases of multiple pregnancy and hydramnion, which present a disproportion between the passive distension and the active growth of the uterus, and which frequently are complicated with hyperemesis, confirm this view. Moreover, the induction of artificial abortion, our last resort in desperate cases, which almost immediately relieves the patient when done in time, is founded upon this theory of passive uterine distension, and strongly supports it.

Spontaneous death of the fœtus, followed by immediate or remote abortion, is another remarkable fact in favor of this view.

A patient of mine, the mother of two children, was suffering from double laceration of the cervix, erosion and endometritis. She refused surgical treatment, and was relieved by repeated irrigations of the uterus with carbolyzed water, and by the application of tincture of iodine. She soon afterward conceived, and her pregnancy was complicated with the ordinary morning-sickness from the second month to the beginning of the sixth, when the vomiting suddenly ceased. Two weeks thereafter she told me that she did no longer feel the movements of the fetus, that vomiting had ceased, and that she therefore believed the child was dead. Though I could not detect the fetal heart-sounds, I gave my opinion with reserve. Three and a half months later I delivered her of a dead fetus about five months old.

This case affords the most striking evidence of the discontinuance of reflex symptoms after the removal of the exciting cause. We have here pregnancy complicated with pathological conditions of the uterus, as double laceration of

the cervix, ectropium and probably a but partially cured endometritis, conditions which existed prior to conception and continued after the death of the fœtus. But in spite of the persistence of these pathological conditions of the uterus, and of the retention of the dead fœtus for almost four months, the vomiting disappeared with the death of the fœtus, that is, with the cessation of the mechanical distension of the uterine cavity.

The influence of primary gravidity is demonstrated by the fact that hyperemesis in its grave forms is essentially an affection of primiparous woman, and it is to be referred to the greater resistance of the virginal uterus.

Numerous other causes are given as etiological factors by different observers, among them: pathological conditions of the cervix, chronic metritis and endometritis, displacement of the uterus, inflammations of the pelvic peritoneum and connective tissue, ovarian neurosis, neurotic predisposition, hysteria, and lastly, disease of the gastro-intestinal canal, especially gastric ulcer, chronic gastritis and constipation.

Morbid changes of the uterus are frequently the cause of reflex neuroses in non-pregnant women. The dependence of gastric disturbances upon the irritability of the uterine nerve-fibers, due to flexion and version of the uterus, to an eroded and congested cervix, to metritis and endometritis, has, in many instances, evidently been proven. Relief has been obtained by the removal of the exciting cause, by the treatment of the uterine diseases after gastric medication had been tried again and again and had failed entirely.

Bearing in mind the physiological changes of the uterus during the pregnant state, its increased functional activity, the influence exerted by gestation upon the nervous system, and the relation between the neuroses and the disorders of the reproductive organs, so often conclusively proven in non-gravid women, we are compelled to acknowledge the various pathological conditions of the uterus as prominent etiological factors deserving our earnest attention. Cases are on record where the application of caustics to the eroded cervix, scarification of the congested vaginal portion, dilation of the cervical canal, correction of a flexion, have proven successful in stopping the vomiting, and thus demonstrated the connection between the uterine lesion and the reflex nerve action. In other instances, however, the result of the gynecological treatment has not been so satisfactory, either transitory or no relief has been obtained, and, as a consequence, the influence of the uterine disorders upon the gastric phenomena, their importance as the causative diseases has been questioned.

Undoubtedly it will be often found difficult to decide

whether the symptoms result from physiological or pathological causes; whether they are due to distension of the uterus or to morbid changes in the sexual organs. All methods of treatment, artificial abortion excepted, may fail to relieve the patient, and she finally may get well by absolute rest and complete abstinence to the surprise of her medical attendant.

Such cases are certainly rare, while, on the other hand, there is abundant clinical evidence of the effect of local treatment. Numerous women have been benefited by the treatment of the uterine lesion; the reflex symptoms have been mitigated or cured by the improvement of the causative disease, and the connection between both has thereby been confirmed.

Attention has been drawn to the importance of endometritis as an etiological factor by F. Veit,\* who reported three cases of uncontrollable vomiting, where he was compelled to interrupt pregnancy, and where he found inflammatory processes in the decidua serotina and vera. Veit believes that by his researches the dependence of hyperemesis upon endometritis is positively proven. As a rule, the endometritis exists prior to gestation, the symptoms are but insignificant, became palpable, however, with the beginning of pregnancy, which frequently is interrupted by this complication. In many instances the endometritis will be found to be the cause of the uncontrollable vomiting; the connection through sympathetic paths must be the same as between gastric disorders and endometritis in non-gravid women. The evidence of an anatomical base, he continues, renders a most careful examination of the uterus imperative and, if the diagnosis of endometritis, which is very difficult before the removal of the ovum, can be made out, it may be of determining influence as regarding the advisability of introducing abortion.

Quite recently E. H. Grandin,† discussing this subject in the New York Obstetrical Society, suggested ovarian neurosis, pressure or unusually hyperesthetic ovaries as a cause of hyperemesis. This view, he says, would be suggested by Dr. Coe's case, which showed that the physiological vomiting of pregnancy could be palliated by teaching the patient to assume the genu-pectoral position before rising, and as often during the day as necessary. He would explain the vomiting of pregnancy, then, by the fact that during the early months the uterus lay low in the pelvis and pressed on the ovaries; at the third month, when the vomiting usually ceased, the uterus rose above the pelvic brim. In cases of pernicious vomiting it was possible the ovaries were either enlarged through disease or had

\* *Berliner Klinische Wochenschrift*, 1887, p. 613.

† *American Journal of Obstetrics*, 1890, p. 1382.



become impacted between the pelvic brim and the lower uterine segment.

Grandin's theory, though it may be applicable to a given case, will probably not be favorably accepted. To-day the view is predominant that reflex-neuroses may originate in the uterus and not in the ovary. The removal of normal ovaries for the relief of reflex symptoms is at present restricted to exceptional cases, and it is believed that if a satisfactory result is obtained by the operation, this is due to the changes in the condition of the uterus, to the artificial induction of the menopause, resulting from oöphorectomy. Clinical evidence supports this view.

Grandin's explanation, however, may prove valuable in so far as to induce us to carefully examine the ovaries in cases of hyperemesis. Prolapsed ovaries are by no means a rare affection, but it remains to be demonstrated whether pressure exerted upon them by the enlarged uterus stands in causal relation to gastric disturbances.

Nervous disposition and hysteria, so frequently met with among women of the better classes, add greatly to the discomfort of pregnancy, and though there are certainly many exceptions, must be considered as prominent predisposing factors of the graver forms of vomiting.

The importance of diseases of the gastro-intestinal canal, especially of gastric ulcers, is emphasized by various authors. According to Horwitz\* "hyperemesis develops in some cases complicated with more or less pathological changes of the stomach and of the intestines. The greater the disturbance in the alimentary canal the easier the ordinary vomiting takes on the character of the uncontrollable form."

The diagnosis of vomiting of pregnancy is by no means as easy as one might think at first sight. While the dependence of this disorder upon the pregnant state may often be determined without much difficulty, cases—especially of the graver forms—may present themselves where this will be found impossible, and where the diagnosis, therefore, must remain doubtful. Jaggard† directs our attention to the fact "that so few cases of pernicious vomiting are recorded in German medical literature that the existence of this affection is even questioned." Carl Braun, in a fabulous experience of over one hundred and fifty thousand obstetrical cases, has never observed a single fatal termination. On the other hand, Robert Barnes has seen nine fatal cases. McClintock collected close on fifty cases, and O. W. Doe forty-eight cases with eighteen deaths occurring within the last fifteen years,

\**Praktischer Arzt*, 1882, p. 261.

†*American System of Obstetrics*, Vol. I., pp. 411, 415.

and registered in American and English journals. Gueniot records 118 cases with forty-six deaths.

It is not at all improbable, Jaggard continues, that the difference of opinion as to the frequency of this disorder between the Germans on the one hand, and the American, French and English observers on the other, depends, in a large measure, upon the difference in diagnostic criteria insisted upon by the respective schools. In the majority of the fatal cases of alleged hyperemesis due to pregnancy reported by American, French and English observers, there is a notable absence of reliable records of *post-mortem* examinations. In the few cases collected by the Germans, on the other hand, the diagnosis during life has almost invariably been confirmed or negated by exact investigation of the dead body. Horrocks pertinently remarks: "Where there has been no *post-mortem* examination in a fatal case of vomiting, I do not think one is entitled to say that pregnancy caused the fatal vomiting. It may have been the cause, and the only cause, or it may have been an aggravation of some other cause, or it may have had nothing to do with it. Scepticism as to the alleged frequency of this disorder in the present state of our knowledge is accordingly eminently in order."

According to Gueniot\* three distinct factors are to be taken into consideration in making the diagnosis of vomiting of pregnancy: (1) The diagnosis of pregnancy; (2) the diagnosis of the adjuvant or determining cause of the vomiting; (3) the differential diagnosis between obstinate vomiting due to pregnancy and that due to other causes independent of gestation.

It is both interesting and instructive to learn that errors in diagnosis have been made even by eminent clinicians. Thus Jaggard† tells us that Trousseau once diagnosticated uncontrollable vomiting, and induced abortion in a case in which the autopsy revealed cancer of the stomach. Beau erred in diagnosis in a case in which the *post-mortem* examination showed tubercular meningitis as the probable cause of the vomiting, and Cazeaux narrates the history of a fatal case of alleged hyperemesis of pregnancy where the autopsy disclosed tubercular peritonitis and the absence of pregnancy.

But a mistake in diagnosis is possible even in the other direction, that is, pregnancy may be denied by the patient or not be expected by the physician, and thus be overlooked, as shown in a case recently reported by A. H. Buckmaster‡. The patient, a governess in a respectable family, was supposed to be suffering from vomiting due to ulcer of the

\*Jaggard, American System of Obstetrics, Vol. I, p. 416.

†L. C.

‡American Journal of Obstetrics, 1890, p. 1381.

stomach, and was under treatment two months when she died. In making the autopsy a five-months' fœtus was found, but no ulcer whatever, nothing to account for death except the uncontrollable vomiting of pregnancy.

These cases need no comment. I have cited them to demonstrate both the difficulty and the importance of an accurate diagnosis.

It is generally stated that the prognosis of hyperemesis is bad, but this, apparently, is by no means correct. As Jaggard justly remarks, "it is doubtful whether an authentic fatal case of this kind is recorded. Such cases have never been seen by observers of the largest experience."

Even the graver forms of this disease yield, as a rule, to rational treatment, unless they are complicated by serious pathological conditions which of themselves render recovery impossible. Pregnancy may aggravate such cases, and perhaps hasten death, but it must be admitted that there exists no causative relation between gestation and the lethal issue.

A great variety of remedies—still increasing in number every year—have been recommended by different writers. These remedies have proven satisfactory in some cases, but failed entirely in others. This uncertainty of the various methods of treatment, the often but little annoyance caused by the milder forms of vomiting, and the experience that in many instances spontaneous cures occur, have led to the view that interference is not required unless the case presents a more serious aspect. Such advice given in text-books is, at first sight, surprising. Even in mild cases of gastric trouble a careful examination is indicated, and should be insisted upon by the medical attendant to determine the cause of the disorder, its dependence upon physiological or pathological conditions. Are the generative organs found to be normal? Are there no indications of diseases of other vital organs, especially of the stomach? Is the effect of the vomiting upon the general health but insignificant? It may then be decided whether it be a wise plan to irritate the stomach by various drugs, which, as known from experience, are of so limited value in this reflex affection, or to desist from treatment. It is in this sense, I take it, that such advice has been given, and it is under these circumstances that it deserves recommendation. Nevertheless, such statements in text-books are misleading, fortunately, but to the superficial reader.

While mild cases of vomiting do well without treatment, diet and regulation of the bowels are usually sufficient to render the gastric disturbances tolerable, but the persistent vomiting demands our earnest attention.



Hyperemesis, a reflex neurosis, is due either to physiological changes in the uterus, distension by the growing ovum, or to pathological conditions complicating pregnancy. If we exclude co-existent diseases of the stomach, which will be considered later on, it must seem plausible that the treatment should be directed against the causes and not against the symptoms of the gastric disorder; that is, against the uterus, and not against the stomach. The stomach is not the diseased organ. Nausea and vomiting of pregnancy are only the symptoms of some functional disturbance of the nervous system, originating in the uterus, like the nausea and vomiting of seasickness, an analogous disease, dependent upon the motion of the ship. For this reason gastric medication must fail to favorably influence hyperemesis; for this reason none of the innumerable remedies recommended are found to be reliable—some of them are worse than useless.

There are three classes of cases, however, which sometimes may be relieved by the administration of drugs, viz: (1) Women who, prior to gestation, have been afflicted with diseases of the stomach, as chronic gastritis and gastric ulcer; (2) Women of an unusual nervous irritability; and (3) Hysterical women.

In cases of the first category, sub-nitrate of bismuth, bicarbonate of sodium, Carlsbad water, oxalate of cerium, the tincture of *nux vomica*, etc., may be tried and may sometimes be found of decided value, while the nervines and sedatives may give relief to nervous and hysterical women. Opium and its preparations, the bromides and chloral, either administered by the mouth, by the rectum, or hyperdermically, as the circumstances require, are the medicinal agents which have the best reputation, and which, in these cases, sometimes successfully depress the reflex irritability, and thus alleviate the symptoms. Blisters, the application of chloroform, ether, and of the faradic current to the epigastrium, of the ice-bag to the dorso-lumbar region have been tried and have afforded relief in some instances.

The resort to local treatment is indicated in all those cases in which a morbid condition of the uterus has been made out. Retroflexion and retroversion are to be corrected, and, if necessary, the uterus is to be retained in position by a suitable pessary. A congested vaginal portion may be relieved by scarifications, while the application of carbolic acid, or of a 10 per cent. solution of nitrate of silver to the eroded cervix will often prove successful in mitigating the distressing symptoms. Jaggard\* states that in Vienna a 10 per cent. solution

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\* L. c.

of nitrate of silver is employed in all cases of severe vomiting, irrespective of the condition of the vaginal portion. "The weight of testimony in favor of this simple procedure, collected from innumerable sources, is so great as to make its employment absolutely obligatory before resorting to more radical methods."

Dilatation of the cervix—Copeman's method—has proven successful according to some writers, while others report negative results. In the only case of severe vomiting which I have observed it had a most remarkable effect. The nausea disappeared instantly, but only for a few hours. The method was again applied, but no result was obtained the second time.

Horwitz\* recommends that in the severer cases of vomiting the patient should be placed at rest in bed in the horizontal position, that the room be darkened, and that, if the stomach rejects everything rectal alimentation should be resorted to. Crushed ice to quench the thirst is allowable. I can fully endorse this plan.

When these various methods have failed, when the vomiting actually is uncontrollable and seriously endangers the patient's life, the induction of abortion or premature labor is indicated, and will, if done in time, to a certainty save the woman.

#### DISCUSSION.

Dr. Le Moyne—I agree with the doctor that in a great many cases vomiting is largely due to abnormal conditions of the parts. I had the same experience with obstinate vomiting in this condition, and found it often was relieved by the correction of some erosion or displacement, although I do not believe that that always caused the condition. The doctor has very wisely laid a great deal of stress upon the matter of careful examination of the parts where these conditions exist, with the view of ascertaining and removing any such abnormal conditions.

Dr. Lange—An excellent paper the doctor has given us; it deserves our thanks. It is very comprehensive and thorough, and there is nothing in it to which any one can raise any objection, except perhaps this: the rectifications of displacements of the uterus during pregnancy by the use of pessaries. That, in my experience, is impossible. In an impregnated uterus, and perhaps in a uterus which is not impregnated, I think that it is beginning to be thoroughly understood that the pessary is a means of absolutely no value, sometimes of great discomfort, and occasionally of some danger. The only pessary which may, perhaps, be sometime of service is the ordinary

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\*L. c.

balloon pessary, a rubber globe which is ballooned up by inflation with air or water. This, in my experience, prevents the descent of the uterus in some cases.

The stem-pessary of Dr. Kinloch may also be an exception to the rule, that pessaries are useless for uterine displacement; this can be used of course only in the unimpregnated uterus, and may deserve consideration in flexions. Among the remedies which the doctor has mentioned are the most valuable, but I failed to hear calomel. Calomel has been, in my experience, a most valuable remedy. In proof of this, I had a lady under my care who had twice suffered abortion at four months, at the hands of the most eminent gentlemen in the profession, because of pernicious vomiting, and their conclusion was that she would die. At her third pregnancy she and her husband again concluded that she would die, and she certainly looked like it. Her adipose tissue had disappeared, her muscular system had atrophied, her belly was distended and tender, she was blanched, her pulse was small and rapid, she had an elevated temperature, and her tongue was red and dry. I gave her calomel, one-eighth grain every three hours. In forty-eight hours she was able to retain *some* food, in two weeks she left her bed, still sick, still vomiting, but able, despite her vomiting, to take a sufficient amount of food to maintain life and improve her condition. That is one instance where calomel exerted a very marked good effect, and this was not due to any organic disease of the stomach; sufficient proof of this is the fact that, before her pregnancy she was always well, and the same was true before her previous pregnancies. She is the wife of a druggist in this city. I give calomel frequently in the vomiting of pregnancy, but in the case relating it strikingly exhibited its power. The doctor mentioned a remedy with which I have no experience in the vomiting of pregnancy, but of which I have heard much good. I have always understood that the introduction of that method belonged to a Pitts-burgher, namely, Dr. M. O. Jones, of Wylie avenue, who informed Dr. Marion Sims of it; the latter teaching it in Paris in 1870. I have always understood that dilatation of the cervix and the separation of the membranes a little way up, which is said to be a very excellent remedy for ordinary sickness of pregnancy, is the method of Dr. Jones.

Dr. Dagette—The doctor speaks of increased temperature being one of the symptoms of pernicious vomiting. Is that one of the signs which arise before death?

Dr. Blume—In my case, after about two weeks had passed, fever commenced, and after another week had passed,



the woman still in bed, her temperature went up to 103 and remained at that height for several weeks, and this case recovered without any medicine whatever, having nothing but absolute rest. She was in bed about six weeks.

Dr. Batten—I have had two cases of severe vomiting of pregnancy. One was in the person of an unmarried woman. At first I could not imagine (she was supposed to be a virgin) what the trouble could be. She was emaciated and her eyes were sunken; after two or three days my suspicion was aroused. There was no fever. The case went on for two weeks under my treatment with all the remedies that I knew of, excepting local applications, and from the fact that the young woman made the request that I keep her mother in darkness as to the cause of the trouble, I was prevented from making any local applications. But after exhausting everything I returned to blackberry brandy and stopped all medicine; after giving her the second dose, the vomiting ceased and she recovered after taking the remedy for some three weeks. Another case I had in 1882. A woman had seven children and never had any vomiting whatever; in this case the vomiting appeared at the end of the first month, and continued right along to the end of the fifth month, and all remedies seemed to have no control whatever of the trouble. However, at the end of the fifth month, after I had given up the treatment, she was not so prostrated as the other case. It was a twin pregnancy, and when that woman was delivered one child was fully developed and another was dead, having died evidently at about the fifth month, about the time the sickness left her. The dead fœtus was in the neighborhood of five or six inches long. The woman ran on to full time.

Dr. Connell—One point the doctor alluded to, the use of nitrate of silver. My attention was first called to the use of this remedy by Dr. Jones, whose name has been mentioned, and I think to him belongs the credit of the introduction of nitrate of silver in the treatment. In the *Journal of the American Medical Association* of two years ago, there was a paper written by a gynecologist or obstetrician of Washington, whose name I can not now recall, and in reply to that, Dr. Jones gave his experience in the use of nitrate of silver, and alluded to having spoken to Dr. Sims about it. Dr. Jones used that many years ago, and it is only a few years since the attention of the profession was called to it. I have used it and had better results with the application of the nitrate of silver than with any other remedy.

Dr. Huselton—I want to say a word in defence of the pessary. I think that we have displacements of the uterus in

the early stages of pregnancy. I also believe it possible to rectify them and maintain them in proper position by the use of Thomas' retroversion pessary. I have certainly replaced retroverted uteri and maintained them in position with this pessary. With regard to treatment, as has been properly stated, I do not know of any one remedy that will relieve all cases. I remember a very aggravated case I had a number of years ago, in which I tried everything that I could think of, which I afterwards succeeded in relieving entirely with a large dose of chloride of potassium.

Dr. Green—I have no criticism to offer on the paper. I wish to relate a case of vomiting during pregnancy which came under my observation on the 6th of this month. The lady was three months pregnant. She had been treated by two or three physicians previous to her application to me. I do not know what remedies she had taken, but no relief had been afforded by any of them. I found her very much prostrated, and for five or six weeks she had had difficulty in retaining food sufficient to afford nourishment; she had not rejected all the food and was still able to go about. An examination of the uterus discovered it to be displaced, retroflexed and apparently bound down with adhesions, and abortion was about to take place. There was evident hemorrhage, which had begun some time the previous night. She miscarried on the second day after I saw her. Again, I wish to say a word in regard to the use of the pessary. Whilst I have no doubt that the pessary may in certain cases do some damage, I have seen what I supposed was benefit, what I supposed was very great benefit, in the use of the soft pessary: especially in cases coming under the class where displacement can be assigned as the cause, I have seen permanent relief. I wish to say a word about the damage sometimes done by pessaries. About six weeks ago I delivered a lady at term. On making examination, I found a common ring pessary, hard rubber. I said: "How long have you worn this?" She replied, "About five years." Six years previously she had given birth to a child and immediately after that this pessary had been placed in the vagina and remained there ever since. I removed the pessary, and saw that it had done no harm. This, I presume, does not very often occur. It shows that the pessary does not always do very great damage.

Dr. Werder—I have no personal experience in this matter. I have had a large number of pregnant women under my observation, but have never seen a case of serious vomiting of pregnancy. There is no doubt that vomiting of pregnancy is a reflex neurosis—of course that is not saying very much—

but I think in a large number of cases it is a form of hysteria. A number of cases have been reported which were treated as hysteria and got well under that treatment; before that, other methods of treatment were employed without any benefit whatever. I think there is no doubt that a large number of cases are hysterical in their character. In regard to pessaries, I have no doubt that pessaries are used very much, and very many women would be far better without them, but there are exceptions to that. I think a good many women would not feel comfortable without the pessary. If the uterus is properly replaced and in normal position and a pessary is introduced where there is no inflammatory condition of the pelvis, in many cases it does a great deal of good. Many of these women feel very comfortable wearing a pessary for months, and women come to me with pessaries where there is no flexion at all, where there is no displacement of the womb, and sometimes there is a displacement, but it has not been reduced at all, the uterus is retroflexed just the same as it was before the pessary was introduced. In pregnancy I have had probably two or three cases of this class, and am certain that these women suffered before the uterus was put in position and before the pessary was introduced, and the benefit they derived from the pessary was also very great.

Dr. Davis—Dr. Blume certainly covers the ground in every particular very thoroughly, and there is one point that he dwelt on and that is, as he said very aptly, you would think that the diagnosis of pregnancy was a very easy thing, and yet I believe this is an important point of the question for discussion to-night. I believe that on that hangs the treatment, and that is the reason why such various treatments are recommended, and why in some cases one treatment acts very favorably and another treatment is of no effect. I think it stands to reason that if pregnancy is the cause of this vomiting, calomel would have very little effect. I think it stands to reason that if there is no (or very little) trouble of the uterus, but if there is a disease of the stomach, calomel would be very beneficial. And, therefore, while in one case I would expect benefit from it, in the other, it would be *nil*. On one occasion I was called to see two ladies, neighbors, both suffering with morning sickness of no aggravated form, but enough to give them great discomfort. To the one I prescribed to the best of my judgment what was wanted, bromide of potash. In the other I prescribed hypophosphites in an acid solution. I remember distinctly, they were given in quite large bottles; they each used about half of the bottles, which were given within a day or two of the same time, and were none the better, but rather



grew worse. Talking, as neighbors will do, over the back fence, they compared notes and traded bottles and were completely relieved. The explanation is simply this, that the acid and the hypophosphites in the state of the one stomach was just what was needed, while the nervine and the alkali was just what the other needed. I believe that as far as we possibly can we ought to ascertain what is producing this particular sickness in this particular woman, and not take it for granted that all morning sickness are from identically the same cause. In my experience I have seen a great many severe cases. Pregnancy acts differently in different persons, and the thing that would remedy one case would be useless in another. I have seen a good many that I considered very severe cases, but it has been my lot to see one that was of unusual severity, at least the result shows it to have been so.

A lady whose medical history I know comparatively little came under my observation for four visits. She was several months gone in pregnancy and was suffering with profound morning sickness. A particular characteristic of it, as I noticed in these four visits, which extended over about ten days, was ptyalism. In fact in my presence she was so overcome that she had to vomit. As I was seeing the case in connection with another physician, a friend and relative, who had been there about an hour before my last visit, I did not push the investigation at that time, as I had no particular alarm. That was on Thursday evening. It had been the case for the husband to drop in and tell me how she was feeling, and to telephone if she was feeling unusually bad. Thursday evening I saw her last. Sabbath morning the physician dropped in and told me he had called and found her in a very critical condition. It seems that on Friday morning a lady physician had been called in, and on Friday and Saturday had seen her in this condition of increasing irritation of the stomach, and vomiting of some cloudy fluid, and on Sabbath morning when her friend, the physician, saw her, she was in a critical condition, and in spite of dilatation and everything else that could be accomplished on Sabbath night, she died on Monday. I felt impressed at the time, and more impressed on hearing Dr. Blume's paper to-night, that a *post-mortem* examination should have been held on the case.

Dr. Koenig—It seems to me that in looking for a specific cause of vomiting in pregnancy, we overlook the fact that the nervous system is very powerfully affected by the pregnancy itself. Vomiting in pregnancy is so common that it can not be due to a gastric lesion; it must depend on an irritation of a nerve ganglion that transmits it to the brain. It has been said

that it is impossible to explain why the peculiar motion of a ship should produce vomiting; I have never heard it explained; I do not suppose we can explain it; nor can we explain satisfactorily how the vomiting of pregnancy is produced.

It would appear to me that the action of all remedies that are of any value can be accounted for in two ways, one a counter-irritation, which would explain the action of pessaries: explain the action of nitrate of silver when applied to the os; and would explain the action of dilatation. By these an irritation is produced which diverts the attention of nature from the disturbing causes which produce vomiting. The artificial irritation at the os distracts the attention of nature from the other point of irritation, and the vomiting ceases. The other action to which I refer is an anæsthetic action applied to the terminal nerve filaments of the stomach. I have recently seen a remedy possessing this action recommended, which Dr. Blume did not refer to in his paper, namely, menthol, in two grain doses. Menthol is a powerful anæsthetic, and by deadening the sensibility of the nerves of the stomach, I can very readily conceive how the vomiting might be arrested. We all know the tendency of disease toward recovery, and if vomiting in pregnancy is a disease, it is especially true in this case. That fact accounts for the numerous remedies that are said to be corrective. That fact might account for the results that followed the exchange of remedies in the case alluded to by the president. A large majority of cases recover without medication.

Dr. Duff—I would make the distinction in discussing this subject between simple vomiting during the ordinary morning sickness of pregnancy, the more persistent and aggravated vomiting, and the pernicious vomiting. There is a conservatism of nature in the first class; indeed, some observers declare this to be so, inasmuch as women thus affected go through their pregnancy as a rule better than do those who are not. The pernicious vomiting due entirely to pregnancy without complications is, I think, a rarity. The failure up to this time of observers to agree upon any common cause of vomiting during pregnancy is *prima facie* evidence of varying causes. Our treatment, therefore, should depend upon a rational consideration of each case presented to us. In the cases of Dr. Davis, I do not think that when the exchange of medicine was made the patients were about to get well. I think the exchange was a happy one, inasmuch as the then treatment was in accordance with the acid or alkaline condition of the secretions. I did not notice that the doctor said anything about electric treatment. I think it is sometimes efficacious. Another mode of treatment

is the application of cocaine to the cervix uteri. Injecting it into the tissues of the cervix, I think gives the best results, although painting with a 15 per cent. solution may answer as well.

Dr. Blume—It has been said that pessaries should not be employed to retain a gravid uterus which has been retroflected. Vomiting, as a rule, occurs during the first few months of pregnancy; the replaced uterus will at so early a period of gestation often need a support or become again retroflected. We have two means to retain the uterus in its normal position: 1. Tampons. 2. Pessaries. Tampons must frequently be changed; are therefore inconvenient and even injurious, as they may incite contractions and thus produce abortion. A suitable pessary does no harm under these circumstances, as I have seen in many instances. Stem-pessaries can not be considered here. In my opinion they should never be used. They are certainly contraindicated during pregnancy.

Calomel has not been mentioned by me because it failed entirely to influence the gastric disturbances in my cases. It acts as a simple purgative, and is indicated or may be tried in cases complicated with costiveness.

Gastric medication is applicable only in the milder forms of vomiting. Cases of pernicious vomiting, where everything is rejected by the stomach, can not be relieved by drugs, be they given by the mouth, by the rectum, or hypodermically. It may sometimes be possible to stop the vomiting for a few hours, but, as a consequence, the nausea becomes so intense that the patient feels relieved as soon as the vomiting commences again.

One gentleman said that dilatation of the cervical canal has been practiced many years ago. This method, first recommended by Copeman, justly bears his name: Copeman's method. Dilatation of the cervix, if carefully effected, does not interrupt pregnancy. But if the internal os is dilated, or, as one gentleman recommended to-night, if the membranes are detached around the internal os, abortion will probably be the consequence.

The view, expressed by one gentleman, that patients with the ordinary vomiting do better at term than those without this disorder, is at least surprising and by no means supported by experience.

In conclusion I wish to *touch* a point which I have not discussed in my paper, viz: when has the vomiting become uncontrollable, and when is the induction of abortion indicated? This question is a very important one, for if we wait too long the woman will in all probability lose her life. Uncontrollable



vomiting is apparently very rare in our vicinity. The case reported by Dr. Davis is the only one I heard of in this city, and I regret that no autopsy has been made. In New York where this subject has been discussed in the Obstetrical Society last fall, pernicious vomiting must be a rather frequent complication, as almost every speaker reported cases where artificial abortion had to be induced to save the patient. Several women died, the evacuation of the uterine contents having been too long delayed. All the speakers agreed that abortion should be induced before the condition of the patient had become critical.

I believe that no precise rules can be given as to when to empty the uterus, and that case must be treated according to its peculiarities. When the various methods of treatment have been tried in vain, when the patient becomes more and more emaciated, it seems hazardous to wait for the most extreme degree of exhaustion. A consultation should be held and the induction of abortion, the last chance of saving the woman's life, should not be postponed too long.

Dr. LeMoyné—In December, 1890, I was requested to see a woman in consultation, who was supposed to be six and a half months' pregnant. She had been delivered of two children at full term previously and had one miscarriage at about six months. For about two weeks she had noticed some swelling of the lower extremities and a specimen of her urine, which was procured the evening previous to my attendance, was found to be so largely composed of albumen as almost to solidify by boiling. She had taken her evening meal with her family, between six and seven o'clock, but while at the table experienced considerable pain in the abdominal region, and was compelled to retire before finishing. She was assisted to bed and medical attention procured. Between that time and six o'clock the following morning she had three very decided convulsions. At six o'clock A. M. her expression was rather dull, but she responded intelligently to questions and recognized persons who addressed her. The mouth of the uterus was sufficiently patulous to admit the point of a finger, which readily detected the body of the fœtus. No instrumental apparatus being at hand for the dilatation of the neck of the uterus, suitable appliances were immediately sent for. But the patient's condition being such as to promise an early return of the convulsions admitted of no delay, and dilatation was practiced with great perseverance and determination by means of the fingers. The success of this method was such that when the Barnes dilators and parallel steel blades arrived, the divulsion was beyond their capacity, but not sufficient to admit the hand. At 9 A. M., no relief being experienced and every

moment seemed to endanger the patient's life, the long obstetrical forceps were resorted to with the intention of either grasping the fœtus in their blades and forcing it away, or effectually dilating the mouth of the uterus by delivering the forceps in the locked position.

The first mentioned plan failed, as no engagement could be procured; but with little difficulty the blades were successfully introduced, locked and gradually delivered, dilating the uterus sufficiently to enable the hand to enter, seize the thighs of a breech-presenting fœtus, and accomplish its speedy delivery. Two modified convulsions occurred after the delivery, and five severe ones previous to it. The normal function of the kidneys was soon reëstablished, and a very satisfactory recovery soon followed.

I offer the history of this case, believing it to illustrate a very valuable and nearly always practicable method of dilating the uterus, and thinking that it may be new to others as it has been to me.

Dr. Duff—The simple introduction of the forceps through the os, locking them without grasping any portion of the child, and withdrawing them for the purpose of dilatation, it appears to me would be impossible except where the head was still above the superior strait, where there was the same condition in a breech, or where there was an oblique presentation. I have frequently introduced the forceps where the os was only dilated sufficiently to admit of their introduction with the double purpose of dilating and of traction. I think Dr. LeMoyne's method justifiable.

Dr. Blume—If delivery by the head should be impossible, I think it is safest to turn by the hand and extract; a woman could be delivered in that way. I do not know in this case whether the child was living or not. I think we have other measures which should be tried first; for instance, anæsthesia.

Dr. LeMoyne—The dilating of the os, I stated in my paper, was done by physical means. I introduced my fingers, first one finger and then another finger beside it, and finally two fingers and the thumb, until I reached a degree of dilatation that would admit the blades of the forceps consecutively. I also stated that, having no suitable instrument for the purpose when the case was thrust upon my treatment, I had to resort to natural means, and by the time the instruments arrived by which I expected to accomplish dilatation, I had already dilated to a sufficient extent with my fingers to introduce the blades of the forceps, and my diagnosis of the position being still uncertain, I introduced the forceps with the intention of seizing any part which might present. It strikes me as a very fortunate though, and resulted certainly very favorably.

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## Editorial Articles.

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### THE HOMŒOPATHS AND THEIR ATTITUDE.

The International Homœopathic Convention, held in Atlantic City, N. J., last June, is attracting deserved attention. It has so long been fashionable to ascribe the so-called hostility of the regular profession to jealousy and ignorance of the truths (?) of homœopathy, that is with special satisfaction that we encounter something that will prove to intelligent, thinking people that we do not cry down homœopathy because we are unable to rise to sublime heights, and to grasp the ungraspable breadth of *similia*.

To present the case fairly, we can not do better than to quote from a work by Dr. Chas. S. Mack, one of the high priests of homœopathy. Dr. Mack, who is Professor of Materia Medica and Therapeutics in the Homœopathic Medical College of the University of Michigan, wrote a volume of essays on the "Philosophy of Homœopathy," which has been ably and dispassionately analyzed by Dr. Solomon Solis-Cohen in the *Medical News*. The thoughtfulness, scholarly ability, sincerity and candor of Dr. Mack caused the able reviewer to regard him as a fair and reliable exponent of latter-day homœopathy.

Dr. Mack's essays confirm the views expressed nearly



two years ago by Dr. Cohen, namely: (1) that homœopathy is exclusively a system of drug-therapeutics; (2) that it is an exclusive system, arbitrarily devised, and claiming infallibility; (3) it expressly prohibits the endeavor to interpret morbid symptoms as indications of changes in the structure or functional activity of definite tissues and organs, and fixes attention upon the symptoms alone, independently of their origin, as constituting the whole of the disease and affording the sole indication for treatment.

In defining what is and what is not homœopathic treatment, Prof. Mack says: "We have recognized the propriety of avoiding proximate causes of disease; to avoid them is hygienic. We have also recognized the propriety of directly attacking, and destroying, and removing such causes when they exist upon or in the body, by any means not harmful to the patient; this is prophylactic. These hygienic and prophylactic measures are *aside from the subject of homœopathy*, and, as we have seen, are not curative." \* \* \* "We may say, moreover, that curative treatment is invariably the treatment of the patient with a drug (or drugs) indicated by the symptoms which he exhibits."

Hygiene is not homœopathy; prophylaxis is not homœopathy; the symptomatic exhibition of drugs *is* homœopathy. But even this method of giving drugs does not rest upon a knowledge of normal and morbid anatomy and physiology. Dr. Mack says: "The two sets of facts between which a law of cure must define the relation are, on the one hand, unmodified disease-effects, subjective or objective; and, on the other hand, unmodified dynamic drug-effects, subjective or objective." \* \* \* No matter what may be the underlying pathological conditions, if the surface-play of symptoms, unmodified, but correspond to the unmodified dynamic phenomena produced by a drug, then the homœopathist knows that he has an unfailing indication in the treatment of that particular disease. It would, perhaps, be more homœopathically correct to say "treatment of that particular *patient*," for Dr. Mack labors to impress upon his readers that the *disease* is to be ignored, whereas the *patient* is to be treated. By homœopathy, a patient is *cured* of disease; by anything else, he

*recovers* from disease. Dr. Mack defines *cure* to be "such modification of the quality of the vital processes and their effects that whereas these processes and effects were abnormal they shall become normal, and this as the *direct* result (not an indirect) of the medicine used. A drug can be curative only by reason of its dynamic effects upon the patient. Curative treatment is invariably a treatment of the *patient*, and never a direct attack upon the cause of disease."

Does homœopathy, pure and simple, allow a man to profit by experience? Dr. Mack says that "statistics regarding results, in homœopathic practice may afford evidence of the truth of *similia*, but should never constitute our *reason* for the choice of a remedy as homœopathic in a case under treatment. The *reason* for this choice should always be that the medicine chosen is capable of producing unmodified dynamic effects similar to the disease-effects produced in our patient." \* \* \* "To base practice simply on evidence is empiricism." In other words, as Dr. Cohen remarks, the results of treatment are to have no bearing upon the selection of remedies.

There are few mortals, we fancy, who would not make a mental note of the results of a certain line of treatment, and apply the same treatment when a similar case came under observation. Plain common sense would offset this absurd development of *pure* homœopathy.

But Prof. Mack takes special pains to weed out from homœopathy such trifles as hygiene, prophylaxis, etc.; these things are useful, he says, but they have nothing to do with homœopathy. It may be that their usefulness causes them to be outlawed by homœopathy.

Homœopathy is a crystallized piece of arbitrariness; it does not need deep scientific research; it scorns broad medical culture; and effectually provides a barrier to substantial and enduring progress.

\* \* \*

Another, and a favorable, view of homœopathy is presented by our lay contemporary, the *New Orleans Times-Democrat*, June 26, 1891. That worthy daily is in accord with the Hahnemannian school, and wonders why intelligent men, as physicians are supposed to be, can not compose their little

differences and embrace in a brotherly manner. In an editorial, headed "The Homœopaths Make Overtures," the *Times-Democrat* said that the Fourth International Homœopathic Convention, representing the medical science of the most civilized countries of the world, held out the olive branch to their elder brethren of the allopathic persuasion.

We take issue at once with the *Times-Democrat* on a very important point. Homœopathy does not represent the *science* of any country; on the contrary, its peculiar teaching is in direct opposition to true science, founded on observation and induction. Homœopathy voluntarily draws itself apart from true science; and any attempt on its part to offer the olive branch to the regular profession can only be regarded as a ludicrous ignoring of the relation of a part to the whole, or of heresy to orthodoxy.

But the olive branch was offered in the following resolutions:

"WHEREAS, As the proceedings and papers of the Fourth Quinquennial Homœopathic Convention conclusively show that the practice of homœopathy by educated medical men and women has obtained a firm foothold in every civilized country on the globe; and

"WHEREAS, Notwithstanding the untold obstacles and opposition it has encountered, homœopathy has steadily advanced in professional and public estimation, until now at the close of nearly a hundred years of incessant and desperate struggle with its foes, and with the repressive influence of the laws, its future is (humanely speaking) assured: therefore, be it

"*Resolved*, That this International Convention would respectfully suggest to the non-homœopathic portion of the medical profession the question, whether the time has not now arrived when the policy of professional ostracism and legislative repression may not, with advantage, be abandoned as a needless discredit to our loved profession, and as a method of controversy which is daily becoming more and more unpopular and ineffective.

"*Resolved*, That we earnestly suggest that the questions that now divide the medical profession into offensive and defensive factions can never reach a solution, except through those methods of observation, experiment and logic, which form the only effectual resort in all other departments of human knowledge."



In the last resolution it is distinctly stated that the questions that now divide the medical profession into offensive and defensive factions can never reach a solution except through those methods of observations, experiment and logic which form the only effectual resort in all other departments of human knowledge.

Now, who is right, Prof. Mack or the Fourth International Homœopathic Convention? There is a contradiction, and the one or the other must be wrong. Either Prof. Mack teaches correct homœopathy, or he does not; we presume he does, otherwise he would not hold such a prominent position in a homœopathic medical college.

\* \* \*

Oil and water can not mix. In tendering the "olive branch" did our homœopathic friends contemplate an abandonment of their own methods, or did they invite the regular profession to forswear medical and collateral sciences, antiseptis, etc., and cramp their lives in the microscopic circle of *similia*? If they put aside as unnecessary all the glorious achievements of modern medicine, they should not complain if others do not share in their blindness. In their resolutions they speak of observation, experiment and logic. Well, let them use "observation, experiment and logic," and there will be no longer need of homœopathy; it will cease to exist as a medical sect, for its members will become men of science.

\* \* \*

Let us bring homœopathy to our own doors. How did our brethren of the sugary pellet act, last year, when an attempt was made to elevate the standard of the medical profession in Louisiana? Did they move with the procession? Did they put a shoulder to the wheel and try to have passed a law that would license only such men to practice medicine as were trained in methods of "observation, experiment and logic"? The defeat of the medical practice bill was due, in a measure, to the opposition of the homœopaths; still that law was framed in a most liberal spirit and was intended to protect men trained in "methods of observation, experiment and logic."

What would please the homœopaths? Would they unite

with the regular profession in trying to obtain a board of medical examiners that would test a man's knowledge of anatomy, physiology, chemistry, surgery, obstetrics, gynecology and hygiene? Leave out the regular materia medica and practice of medicine, and such special branches as ophthalmology and otology. A knowledge of the branches above mentioned can harm no one. Next year, another attempt will be made to secure the passage of a medical practice bill. If the homœopaths are going to be a disturbing element, it is no more than our right to demand in advance a declaration of the platform or principles on which they base their conduct. Such a declaration should be made in their own organ, and should bear, as much as possible, the official stamp of authority.

The JOURNAL will continue to agitate this matter until something comes of it.

*What will the homœopaths accept as a minimum amount of knowledge which a medical man should possess to practice safely upon his fellow-creatures?*

When that question is satisfactorily answered, we will be in a position to eliminate one element of discord.

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#### McLAUGHLIN'S THEORY OF IMMUNITY, AND DR. MOOR'S THEORY.

In the *New York Medical Journal* for July 18, 1891, appears an article by Dr. Wm. Moor, on "Immunity Through Dynamic Inhibition." The author ascribes immunity to "molecular vibration," and among his conclusions he lays down the following propositions: (a) The normal molecular vibration of the organism checks the growth and multiplication of bacteria; (b) the molecules of the animal organism are endowed with a dynamic inhibitory power; (c) bacteria that enter the animal system can only proliferate therein if they are capable of changing the normal molecular vibration to one that corresponds to their own biological properties.

In the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL,

June and July, 1890, we gave a report of the proceedings of the Texas State Medical Society. Among the papers read was one by Dr. J. W. McLaughlin, of Austin, on "Immunity." The paper afterwards appeared *in extenso* in the published transactions of the society, and numerous reprints were sent to various parts of this country and to all of the foreign exchanges of the JOURNAL.

The similarity between the theories of these two gentlemen is most striking. Dr. Moor is evidently a great reader and student, for he makes over forty references in the course of his brief article. Still, there is a very important and very singular omission: *he says not a word of McLaughlin and theory*, which is almost the counterpart of his own, and which was given to the world one year ago. This strange lapsus is difficult to understand, except as one of those unfortunate coincidences with which Fate sometimes tantalizes men.

The two theories are not identical; and in order to set forth the amount of credit to which each writer is entitled, we can not do better than quote from a letter from Dr. McLaughlin. He says:

"The central argument advanced by Dr. Moor, the one upon which all the others are dependent, is that acute infectious diseases are caused by, and immunity is obtained through, molecular vibrations of bacteria on the one side, and of the animal tissues on the other side. Thus far the premises assumed by Dr. Moor are in accord with those contained in my paper, and as my article antedates his, I am certainly entitled to priority of claim. \* \* \*

"In the further handling of his subject the doctor departs, in some particulars very widely, from the line of argument pursued in my paper. For example, the doctor assumes that the class of diseases under consideration are caused *directly* by molecular vibrations of such bacteria as are capable of changing the molecular vibrations of the whole organism from what he terms their normal state to those of the invading bacteria. When bacteria are not able to change the vibrations of all the organic molecules of the whole organism, the organism, he says, is immune from their influence, and the



bacteria are unable to grow and multiply under these conditions. \* \* \*

“The illustration which follows in the printed text is not applicable to the subject, besides the theory is defective in its entire inability to explain how immunity is obtained through ptomaines. The explanation of these processes [immunity through ptomaines], as set forth in my paper, is, briefly stated, as follows:

“One-celled plants, including, of course, bacteria, possess the power, when placed under favorable conditions, of breaking up certain organic—and sometimes inorganic—molecules contained in the medium in which they are placed. This occurs in various acetic and butyric fermentations, and is also found to occur when pathogenic bacteria act upon the albuminoids of the blood, producing ptomaines, toxines, tox-albumens, etc. The explanation of these phenomena offered in my paper differs from all others, so far as I know. It is molecular vibrations which in periods of time occur in unison with those of certain less stable molecules contained in the medium, the former, through a super-position of waves or vibratory impulses increase the amplitudes of the latter and finally drive them beyond their attractive affinities and thus disrupt the compounds. The molecules thus liberated will, in accordance with chemical laws, immediately re-combine into simpler and more stable compounds. If the battlefield is the blood, the pathogenic bacteria are the assailants, and the unstable albuminoids are the assailed, there would result a disruption of these latter and a re-combination of their constituent elements into ptomaines and tox-albumens. When it is remembered under what vibratory influences these latter substances are formed, it will be readily understood that they must vibrate in periods of time which differ from both the others: that in many cases the vibrations of the ptomaines will more or less completely antagonize those of the bacteria, and when a sufficient amount of the ptomaine is formed it will arrest the disease in accordance with the “law of interference.” It will not only arrest the disease, but will give immunity, more or less permanent, against other invasions of this bacterium. It is thus shown that it is the ptomaine, and not the bacterium as claimed by Dr.

Moor, that is the *direct* cause of the symptoms and pathological conditions which constitute the type of disease.

In order that we may explain in a clear manner how the products of bacterial action, viz, the ptomaines, toxins, toxalbumens, etc., cause immunity, let us bring before us all the factors of the problem. First, we have bacteria whose molecules vibrate in definite periods of time; second, we have the unstable albuminoids, whose molecules vibrate in the same period of time with those of the given bacteria, the result is a disruption of the albuminoid molecules and the formation of certain toxic substances from the elements thus liberated: these toxic substances, ptomaines, etc., will necessarily have molecular vibrations which differ in their periods of recurrence from both other factors; often the molecular vibrations of the ptomaines will more or less interfere with the other vibrations and in this way not only arrest the disease, but will so change the vibrations of the albuminoids that they will no longer be in unison with those of the given bacterium, and hence can no longer be influenced by it. When this occurs the individual will be immune from the influence of the given bacteria, at least so long as the changed molecular vibrations of the albuminoids continue. Are we warranted in assuming that this impress made by the ptomaine upon the albuminoids and manifested by the latter in changed molecular vibrations is of a permanent character, and is transmitted from albuminoids to their successors for a long period of time, perhaps in some cases during the life of the individual, in this way giving permanent immunity? I think we are. A similar change can be worked in the molecular structure of organisms much more firmly fixed than the albuminoids, and this change will be manifested for a long time, and even transmitted through heredity from generation to generation of the bacteria. I refer to the process known as attenuating bacteria. Take for example the bacillus anthracis, which is attenuated by being subjected to a temperature a little short of its thermal death point. These attenuated bacteria are found macroscopically and microscopically to be identical with the unattenuated forms; they multiply themselves by reproduction as do the others, but differ from them in their power of decomposing or breaking

up the albuminoids of the blood—the difference is not one of kind only of degree; they are weakened in this power. Now this power, I claim is the result of the periods of time in which the molecules vibrate, and if these vibrations can be altered in case of the bacteria we are warranted in believing they can be in the albuminoids, much less stable substances.

“Immunity obtained from inoculations of ptomaines in small amounts is practically the same method as using attenuated bacteria for the substance of inoculations; in both cases you get small quantities of the ptomaine and in both you get immunity.”

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#### CONTRACT-PRACTICE IN BERLIN.

The Berlin correspondent of the *Therapeutic Gazette*, July, 1891, gives some racy news from the immaculate German capital. One part of this letter possesses a special interest for the physicians of New Orleans. The correspondent describes the evils of contract-practice as it exists there, and which he denominates “society practice”—precisely what it is called in New Orleans. Our physicians may find some consolation in reading the correspondent’s remarks, and if they do find it they are welcome to it. He says:

“The Berlin physicians are just now greatly agitated by the question of “*Krankenkassenaerzte*” (physicians of sick-benefit societies). Hitherto a member of such a society was compelled to consult the doctor of the society, who received a yearly salary for his services. As all Berlin workingmen and working women are legally compelled to belong to a sick-benefit society, the work of doctors elected by such societies is naturally an enormous one. Their houses are actually besieged by patients, while hundreds of other physicians have no patients at all. The consultations which the “society doctors,” as I will call them, grant to each patient are ridiculously short and absolutely incapable of benefiting the patients.



I have heard of doctors "doing" over one hundred patients a day, and also learnt the number of minutes allotted to various consultations:

Minor surgical cases.....	15 minutes.
Gonorrhœal affections.....	10 "
Headache and other pains.....	5 "
Influenza.....	6 "
Rheumatism.....	6 "
Examination of the lungs.....	5 " etc.

It is evident that this state of affairs is an improper one and equally undesirable for both patients and doctors. To enhance the morbid character of the affair, the compensation of the physicians is a ridiculously low figure, viz: *eight Pfennige* (two cents) per consultation, on an average. This figure is no fancy of your correspondent's brain, but has been officially fixed by statistical investigations and has been published broadcast in all papers. Imagine the blissful state of the practitioner rewarded by two cents for an auscultation of the chest. At last the Berlin doctors have waked up and taken energetic steps towards extinction of this shameful condition."

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Dr. F. W. Parham was elected by the Board of Health, July 6th, 1891, chief sanitary inspector, to succeed Dr. H. W. Blanc, resigned.

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#### AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

The American Electro-Therapeutic Association will hold its first annual meeting at the hall of the College of Physicians, corner Locust and Thirteenth streets, Philadelphia, Pa., Thursday, Friday and Saturday, September 24, 25 and 26, 1891, under the presidency of Dr. G. Betton Massey.

Physicians interested in the discussion of electricity in medicine are invited to attend without further notice.

HORATIO R. BIGELOW, M. D.,

*Chairman Executive Council.*

WM. H. WALLING, M. D., *Secretary.*

*2005 Arch street, Philadelphia.*

## Abstracts, Extracts and Annotations.

### MEDICINE.

#### PNEUMO-THERAPEUTICS.\*

By DR. HOVENT, of Brussels.

Baths of compressed or rarefied air are given by means of seven iron chambers of varying capacity, some being capable of comfortably containing from two to ten persons. Each chamber is well constructed; it is supplied with several windows of glass two centimetres (three-quarters inch) thick; it has a duplicated door, or perhaps better expressed, two doors enclosing a lobby, in which the doctor, entering by the outer door, can shut himself, and then equalizing the pressure, can open the inner door and speedily reach the patient for any purpose, without great alteration of the pressure in the chamber. Another smaller door, also duplicated, serves for the purpose of handing to the patient books or whatever may be desired. Electric bell, elbow chairs, toilet tables, manometer, thermometer, hygrometer, etc., are all at hand.

From the chamber so described emerges six pipes, leading to the underground tanks of 1, compressed; 2, rarefied air; 3, nitrogen; 4, oxygen gas; the remaining two pipes are for the purpose of purifying the air. Each of the first four pipes is attached to a little tank which permits of the measurement of the quantity of air, nitrogen or oxygen introduced into the chamber, or of the quantity of air removed.

The large tanks in which the air or gas is compressed, or rarefied, are ten in number. Each holds several thousand of litres. The compression or the rarefaction of air or gas is obtained by means of a gas engine of eight-horse power. The tanks will bear seven or more atmospheres of pressures, or a corresponding degree of rarefaction.

The manipulations are as follows: If it is desired to place the patient in a chamber, and the pipe connecting the chamber with the tank of compressed air, for instance, is opened, this compressed air rushes in; its quantity can be regulated according to circumstances. The reverse takes place if rarefied air is to be used; the air of the chamber rushes out, and the patient remains in a relative vacuum.

One serious and even capital drawback to the employment of air-baths lies in the fact that in the course of the two hours,

\* Abstract of a communication to the Philadelphia County Medical Society.

the duration of an ordinary sitting, the air within the cabinet soon becomes foul from the processes of respiration, perspiration, etc. The establishment at Brussels is the only one in which this inconvenience is efficaciously overcome. The air is being constantly withdrawn from the occupied chamber, and purified by being passed through several iron Wolff's jars containing chemicals, to be again introduced, the same degree of positive and negative pressure being always maintained.

It may be desirable to impregnate the atmosphere of the chambers with the vapor of a certain medicinal agents; it is an easy matter to place the substance to be used in the path of the air current, or more simply to put some drops of an essence on boiling water into the chambers. Pumiline essence I frequently and successfully use.

The compressed air bath more completely expands the pulmonary vesicles and increases their elasticity; the diaphragm and the base of the lungs descend lower; the respiratory process is more perfectly and less frequently performed; the peripheral circulation is less active, with some degree of decongestion of the skin and the mucous membranes (nasal, laryngeal, pulmonary, etc.); the pulse is less frequent and more full; the appetite and strength increase rapidly; the nervous system is undoubtedly invigorated. One may observe that these effects are corollaries of one another, and result either from mechanical or chemical action; indeed, the oxygen of compressed air is no longer oxygen, but some form of ozone.

The rarefied air bath has not been so well studied; nevertheless, it is employed with much success by some practitioners, who seek in it a reproduction of mountain atmosphere. It has also been recommended for rickety children, when the thorax is deformed. Recently it has been used alternately with the compressed air bath, when a doubt exists as to whether a patient should be sent to the mountains or to the seashore. The therapeutic uses of the air baths are very numerous, but easily deduced from the foregoing considerations.

Asthma is the principal affection for which compressed air baths are employed. Eighty per cent. of recoveries are obtained after from twenty to sixty sittings. During the first sitting the dyspnœa disappears when the pressure of air is sufficient; this result becomes permanent only after a number of sittings.

In pulmonary emphysema the air bath empties the vesicles and increases their elasticity, so that the dyspnœa diminishes. The first sitting is usually followed by a notable improvement. As in asthma, the success is generally striking and permanent.



Pulmonary congestions, pulmonic processes, proceeding or following pneumonia, and hæmoptysis, are cured mechanically since the compressed air provokes anæmia of the pulmonary tissues. Chronic bronchitis and bronchorrhœa are always improved, so far as concerns dyspnœa, cough, expectoration and general health. The first effects of the treatment are an increased expectoration, up to the point of completely ridding the lungs of mucous, and simultaneously a decongestion of the respiratory mucous membranes. The last action must be invoked in explaining the beneficial influence of compressed air in coryza, chronic pharyngitis and laryngitis, and in that exaggerated susceptibility of the mucous membrane, as a result of which the patient is constantly exposed to the danger of catching cold. I have recorded two cases of chronic amygdalitis, in which resection had been contemplated, and in which I obtained complete cures by compressed air baths.

In whooping-cough, "the beneficial action of air baths is undeniable," said Dujardin-Beaumitz. The cure is obtained after from ten to fifteen sittings; and generally the child gains from one to three pounds in weight. Jaccoud charges with gross neglect the physician who does not submit his consumptive patient to aëro-therapy. Oertel thinks the compressed air treatment far superior to climatic treatment in any country. Professor Bertin (Montpellier) has recorded five cases of recovery in consumption in the third stage.

Heart disease has long been considered the only drawback to aëro-therapy, but since I have successfully treated a number of cases with cardiac complications, I no longer hesitate to treat such cases, only using certain precautions.

In catarrhal deafness compressed air effects a natural catheterism. I have not infrequently seen patients suffering from asthma or other complaints emerge from the chamber declaring that their hearing was better than for many years.

Dujardin-Beaumitz says: "Compressed air baths are to be preferred to any other method of treating chlorosis, anæmia, diabetes, albuminuria and gout."

Obesity, also, is favorably influenced, as a result of the acceleration of organic combustion, and the more active elimination of urea and carbonic acid.

In conclusion, I must add that Dr. Arntzenius has cured some cases of neurasthenia, and that I have recorded three observations of dysmenorrhœa permanently cured by a pneumo-therapeutic course. I think these results are due to the general invigorating power of the treatment.—*Med. News.*

# A MOST REMARKABLE FIND.—FOREIGN BODIES SWALLOWED BY A STOWAWAY.

In the issue of the *Lancet*, of London, of May 30, an editorial details the most remarkable “*find*” of foreign bodies discovered in the cadaver of an Arab we ever heard of. We quote as follows:

“On Thursday, May 21, the body of an Arab, found dead in one of the ships in the Albert docks, was taken to the Seamen’s Hospital, name unknown. A necropsy was ordered by the coroner, and made by Dr. F. Croucher, house surgeon to the branch hospital. There were no signs of disease in the brain or the chest, except a few old adhesions in the left pleural cavity. The gall-bladder was very distended and full. Three small ulcers existed on the anterior coat of the stomach. Several patches of inflammation were found in the small intestine. In the cæcum were found twenty trousers buttons, three cog-wheels (apparently out of a watch, two of them 1 inch in diameter—these were doubled), one 2-inch steel screw bent double and one 1-inch screw, six pieces of a lock (the biggest piece was 1½ inches long and ½ inch broad), a circular piece of brass (1¾ inch in diameter folded into four), brass and lead and two key tallies on a ring, 1 inch in length. In the ascending colon, about five inches from the cæcum, were found a piece of steel wire ⅛ of an inch in diameter and 3½ inches in length, bent double, and one small cog-wheel. The weight of these bodies together amounted almost exactly to half a pound. The body was much emaciated; no subcutaneous fat was present in chest or abdominal walls, or any fat around the kidneys. The deceased was quite unknown; no particulars could be discovered by the police employed to take evidence for the purpose of the inquest. There was no perforation of intestines, or any sign of disease in the colon.”

## TREATMENT OF INFANTILE DIARRHŒA WITH SALOL.

Dr. E. Hirtz has established the great value of salol as an intestinal antiseptic; and, according to Dr. Weber, a Swiss physician, it is chiefly in infantile diarrhœa that salol manifests its antiseptic properties, and, in this respect, it is far superior, to other remedies recommended for the purpose.

The effect is produced almost immediately, and in 24 hours the vomiting and diarrhœa cease. Dr. Weber employs the following formula:

R̄ Salol..... 3 grains.  
Laudanum..... 1 drop.

M. And make one package, to be taken twice a day.—*Gazette des Hopitaux*.—*Lyon Medical*.

## LARYNGOLOGY, RHINOLOGY AND OTOTOLOGY.

## DIPHThEROID STOMATITIS—ŒDEMATOUS URTICARIA OF THE THROAT AND TONGUE.

At a meeting of the Paris *Société Médicale des Hôpitaux*, held on July 3, 1891, Dr. Sevestre related a case of *diphtheroid stomatitis* due to the action of *staphylococci*, which had been mistaken for diphtheria. The saliva of the patient was slightly acid; but the majority of the children in the same service presented the same phenomenon.

Dr. Laveran presented a patient, aged 30, affected with œdematous urticaria of the throat. This man had long been subject to outbreaks of urticaria on different parts of his body; at the time of exhibition he had a patch on his tongue and another on his hip.

Dr. Moutard-Martin saw a woman who suddenly awoke one night with a feeling of suffocation and a difficulty in swallowing. The tongue, which was much swollen, projected beyond the teeth. He suspected urticaria of the mucous membrane; at night some patches did appear upon the lips and cheek; in the morning, all trace of the affection had disappeared. A physician who sees these things for the first time is apt to be embarrassed.

Dr. Rendu, not long ago, saw a child, who having at first urticaria of the forehead, face and neck, was seized with urticaria of the throat with alarming symptoms of suffocation. The cutaneous eruption facilitated the diagnosis, which would have been difficult without it.

Dr. Sevestre observed similar phenomena in a woman who had eaten mussels. Some hours after urticaria appeared equally on the skin. One hour later her grandson was seized in the same manner.

Dr. E. Labbé was himself seized, after passing a night with a patient, with a violent attack of asthma and facial urticaria. This attack was due to urticaria of the bronchial tubes. He has since seen a patient attacked in a similar manner.—*Le Progrès Médical*.  
A. MCS.

## BROMOFORM AS A TOPICAL APPLICATION.

By SOLOMON SOLIS-COHEN, M. D., of Philadelphia.

I have recently employed bromoform in a severe case of ozæna as a topical application to the nasal mucous membrane after thorough cleansing with hydrogen dioxide. The absence



of the severe local reaction anticipated, together with the extraordinary success of the measure, not only in destroying the odor but in controlling the morbid secretion, encouraged me, after preliminary trial upon my tongue and pharynx, to use the same agent as a topical application to tuberculous and other ulcers of the larynx, after cleansing with hydrogen dioxide. Here the agent seemed to exert analgesic as well as disinfectant properties, as pain was relieved and healing apparently promoted. The agent being extremely volatile, the immediate effect is transient, and I have, therefore, followed the application of bromoform with insufflation of iodoform in powder. While this somewhat obscures the therapy, yet the effect was better than when iodoform had been used without bromoform in the same cases. This preliminary note is published at this time to induce further trial and report by others.—*Med. News.*

## State News and Medical Items.

### CHARITY HOSPITAL.

At the monthly meeting held July 7, the following members of the Board were present: President, Dr. Bickham; Secretary Edwin Marks; Messrs. Sentell, Keller, McManus, Vincent and Devereux.

The clerk's report for June showed:

Number of patients in hospital June 1, 566; admitted since, 493, of whom there were, males, 336; females 144; under 10 years of age, 19; American, 363; foreign, 130.

Patients discharged—Male, 305; female, 109; under 10 years of age, 14; total 414.

Died—Male, 64; female, 22; under 10 years of age, 9; total, 86.

Patients July 1, 559, of whom there are, male, 354; female, 205.

Daily average during the month of June, 563.

The financial report showed a balance on hand to the credit of the general fund of \$34,374.19; to the credit of the out-clinic building fund, \$16,000.

The report called attention to the following points relative to ambulance duty:

1. Ambulance students are to render aid when needed on the spot.

2. The ambulance corps is an arm of the medical department as a charity to those who need free assistance. Those whose condition does not warrant admission are rejected as they would be if applying for aid at the gate.

3. The students have no authority to act in medico-legal matters; on the contrary, are forbidden to act in such cases.

4. Students are instructed, when in doubt, as to the line of their duty, to take that course that appears to them most compatible with the general rules, including the most humane and charitable view.

The points were set forth owing to "a misapprehension that exists regarding the duties of the ambulance corps."

The pathological report showed 19 autopsies during the past month.

The building committee reported good progress on the female out-door clinic department, the walls of which are completed. Pipes are being put in, and the builders are ready to put on the roof.

Dr. H. W. Blanc's resignation, as dermatologist, and Dr. Warren S. Bickham's, as visiting surgeon, were accepted.

Visiting surgeons J. L. Schmittle and G. B. Lawrason were granted leaves of absence.

Dr. Bloom, Dr. Miles reported, will fill Dr. Blanc's position for the unexpired term of four months.

DR. SOUCHON has returned from Virginia.

DR. MEADOWS returned from Arcadia to Homer last week.

DR. YOAKUM has returned to Shreveport.—*Shreveport Times*.

DR. CHAS. L. SEEMAN and family have returned after two months North and East.

DR. F. M. FAUGHT, of Dallas, Tex., is at Huntsville, Ala., for a visit.

DR. C. N. FALSE celebrated his 4th of July at Donaldsonville.

DR. RANDALL HUNT, of Shreveport, was married at

Franklin, La., May 31, 1891, to Miss Emily Halsey, daughter of the late Major E. W. Halsey.

DR. M. B. TARLETON, of Jeanerette, La., is visiting in Tennessee and Indiana.

DR. and MRS. GAYLE, of New Iberia, are at Biloxi for the summer.

DR. MURRAY, of the Marine Hospital Service, has been ordered to Chandeleur Island to relieve the physicians in charge who are reported ill with yellow fever.

During the absence of Dr. C. W. Jordan, in Mexico, Dr. R. T. Scott has kindly consented to look after his patients, and can be found either at the latter's office or his own in the White building, where he will promptly meet the demands of his own as well as those of Dr. Jordan. The latter has left his patients in good and competent hands.

DR. N. B. NULL, of Ruston, La., returned from his visit to Alabama about a week ago.

DR. A. A. BATCHELOR, a large planter of Pointe Coupee parish, and a prominent anti-lottery member of the Legislature, with his family, is spending the summer months at Biloxi.

MRS. DR. R. W. SEAY left home for New Orleans on Tuesday. We were pleased to meet the doctor in town that day.—*Carroll Democrat*.

DR. HARDY and family, of Columbus, Miss., are at Biloxi.

NORTON—HOWARD.—Last Monday, at Seashore Camp Grounds, was celebrated the marriage of Miss Hattie A. Howard and Dr. Edward W. Norton. The happy couple are well known and much esteemed in social circles in our city. Dr. and Mrs. Norton received showers of congratulations from their many friends on the grounds, who saw them depart the same evening for the mountains of Tennessee, where they will spend the summer in company with their relatives, Mr. and Mrs. Geo. E. Foster.



DR. G. FRANK LYDSTON has been elected Professor of Genito-urinary and Venereal Diseases, in the Chicago College of Physicians and Surgeons.

DR. J. C. CULBERTSON, editor of the Cincinnati *Lancet and Clinic*, has been elected editor of the journal by the trustees of the American Medical Association, at the meeting held recently in Chicago.

On Wednesday, the first day of July, Dr. Edwin Foster, one of the oldest residents of our town, died at his home, surrounded by his family and friends, after a long and painful illness. He was in his eighty-first year, fifty-four of which had been spent in Winston county. He leaves his aged widow, who was his companion for fifty-six years, and five sons and three daughters to cherish his memory and mourn his departure. His body was laid away in the graveyard at the Baptist Church.—*Exchange*.

New York board of health has appointed two women physicians on the "summer corps," who are to inspect tenement houses and give medical advice free to mothers of sick children.

It is now an assured fact that Dr. Bransford Lewis will, immediately upon his return from Europe, commence the publication of a medical and surgical serial, conducted after his own original ideas. The doctor does not as yet reveal the title of the new journal, but has adopted a novel method of bringing his magazine to the notice of the profession. In another part of this issue will be found a design, within which is hidden the name of the magazine, and the doctor proposes to mail it free to those sending in correct solutions.

Dr. Lewis announces his intention of making this journal a surprise to the profession, inasmuch as it will be a departure from the beaten path of medical literature. *The Medical Herald* but voices the sentiment of the many friends the doctor won while editor of the *Weekly Medical Review*, when it wishes the venture abundant success.—*The Medical Herald*.

The rapid extension of leprosy in Russia has excited the alarm of the authorities, and the town council of Riga has

voted 60,000 rubles to establish a hospital for lepers, which is to be inaugurated in July.—*Times and Register*.

*The Medical Record* says Mexico has nine medical schools, in each of which the course of study is six years.

SYMPATHIZED WITH NATURE.—Granger—"Doc, thar mus' be suthin' left whar ye pulled thet tooth for me, last week. It's ached ever sence." Dentist (examining the mouth)—"Nothing there, sir, but a vacuum." "How big"? "Why, about the size of a tooth, of course." "Wal, yank'er out, doc. I knowed suthin' was wrong. I've heerd thet nacher obhors a vackeyum, an' dinged ef I blame 'er 'f she ever got one stuck inter her jaw."

AN EYE TO BUSINESS.—A certain doctor, who was noted for a keen eye to business, was driving along the street of a country town, when his horse took fright and ran away. He was thrown violently out of his trap and rendered senseless. Presently he recovered a little from his unconsciousness, and noticing the crowd which had gathered about him, asked, "What's the matter, gentlemen? Anybody hurt? I am Dr. B——. Can I be of any service"?—*Medical Record*.

#### MODERN MEDICINE.

First they pumped him full of virus from some mediocre cow,  
Lest the small-pox might assail him, and leave pit-marks on his brow;  
Then one day a bull dog bit him—he was gunning down at Quogue—  
And they filled his veins in Paris with an extract of mad dog;  
Then he caught tuberculosis, so they took him to Berlin,  
And injected half a gallon of baccilli into him;  
Well his friends were all delighted at the quickness of the cure,  
Till he caught the typhoid fever, and speedy death was sure;  
Then the doctors with some sewage did inoculate a hen,  
And injected half its gastric juice into his abdomen;  
But as soon as he recovered, as of course had to do,  
There came along a rattlesnake and bit his thumb in two;  
Once again his veins were opened to receive about a gill  
Of some serpentine solution with the venom in it still;  
To prepare him for a voyage in an Asiatic sea,  
Now blood was pumped into him from a lep'rous old Chineese;  
Soon his appetite had vanished, and he could not eat at all;  
So the virus of dyspepsia was injected in the fall;

But his blood was so diluted by the remedies he'd taken  
That one day he laid down and died, and never did awaken ;  
With the Brown-Séguard elixir though they tried resuscitation,  
He never showed a symptom of reviving animation ;  
Yet his doctor still could save him (he persistently maintains),  
If he only could inject a little life into his veins.—*Puck*.

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OFFICIAL LIST OF THE CHANGES OF STATION AND DUTIES  
OF MEDICAL OFFICERS OF THE U. S. MARINE HOSPITAL  
SERVICE FOR THE THREE WEEKS ENDED JULY 18, 1891.

MURRAY, R. D., Surgeon. To proceed to Gulf Quarantine for temporary duty, July 1, 1891.

SAWTELLE, H. W., Surgeon. Relieved from duty at Portland, Me.; ordered to Boston, Mass., July 11, 1891.

IRWIN, FAIRFAX, Surgeon. When relieved at Boston, Mass., to proceed to Buffalo, N. Y., for temporary duty, July 11, 1891.

CARTER, H. R., Passed Assistant Surgeon. Ordered to Washington, D. C., for temporary duty, July 2, 1891.

PECKHAM, C. T., Passed Assistant Surgeon. Granted leave of absence for seven days, June, 30, 1891.

DEVAN, S. C., Passed Assistant Surgeon. When relieved at Buffalo, N. Y., to proceed to Portland, Me., for duty, July 11, 1891.

BROOKS, S. D., Passed Assistant Surgeon. Granted leave of absence for thirty days, July 13, 1891.

KINYOUN, J. J., Passed Assistant Surgeon. Granted leave of absence for thirty days, July 14, 1891.

HOUGHTON, E. R., Assistant Surgeon. To proceed to Cleveland, Ohio, for temporary duty, July 8, 1891.

DEATH.

ASSISTANT SURGEON J. F. GROENEVELT died of yellow fever at the Gulf Quarantine Station, June 29, 1891.



## MORTUARY REPORT OF NEW ORLEANS.

FOR JUNE, 1891.

CAUSE.	White .....	Colored..	Male .....	Female...	Adults ...	Children.	Total .....
Fever, Yellow .....							
“ Malarial (unclassified).....	10	6	10	6	4	12	16
“ Intermittent .....	1		1			1	1
“ Remittent .....	3	4	2	5	5	2	7
“ Congestive.....	12	2	7	7	6	8	14
“ Typho-Malarial.....	2	1	2	1	2	1	3
“ Typhoid or Enteric.....	2	5	6	1	5	2	7
“ Puerperal .....							
Scarlatina .....							
Small-pox.....							
Measles .....	3	2	2	3		5	5
Diphtheria .....	1		1			1	1
Whooping Cough .....	1	1	1	1		2	2
Meningitis .....	13	3	8	8	3	13	16
Pneumonia.....	10	5	7	8	7	8	15
Bronchitis .....	5	2	2	5	3	4	7
Consumption.....	29	35	33	31	64		64
Cancer .....	10	5	5	10	15		15
Congestion of Brain.....	11	3	6	8	9	5	14
Bright's Disease (Nephritis) .....	5	7	9	3	11	1	12
Diarrhœa (Enteritis) .....	45	13	36	22	21	37	58
Cholera Infantum .....	46	24	34	36		70	70
Dysentery.....	10	7	14	3	13	4	17
Debility, General .....	6	1	3	4	7		7
“ Senile .....	11	3	5	9	14		14
“ Infantile.....	7	3	7	3		10	10
All other causes .....	183	92	144	131	164	111	275
TOTAL .....	426	224	345	305	353	297	650

Still-born Children—White, 22; colored, 10; total, 32.

Population of City—White, 184,500; colored, 69,500; total, 254,000.

Death Rate per 1000 per annum for City—White, 27.71; colored, 38.68.  
total, 30.71.HENRY WILLIAM BLANC, M. D.,  
Chief Sanitary Inspector.

## METEOROLOGICAL SUMMARY—JUNE.

STATION—NEW ORLEANS.

Date.....	TEMPERATURE.			Precipn. in inches and hundredths ..	SUMMARY.
	Mean	Max.	Min.		
1	79	87	71	0	Mean barometer, 29.96.
2	80	87	73	0	Highest barometer, 30.23, 4th.
3	80	87	72	0	Lowest barometer, 29.75, 18th.
4	80	88	72	0	Mean temperature, 81.
5	82	92	73	0	Highest temp., 94, 24th & 30th; lowest, 66, 18th.
6	78	89	68	.20	Greatest daily range of temperature, 24, 4th.
7	78	86	70	.09	Least daily range of temperature, 10, 16th.
8	78	87	70	.14	MEAN TEMPERATURE FOR THIS MONTH IN—
9	80	87	74	.02	1871..... 82    1876..... 80    1881..... 84    1886..... 79
10	79	86	72	T	1872..... 80    1877..... 81    1882..... 81    1887..... 78
11	81	90	72	0	1873..... 80    1878..... 82    1883..... 81    1888..... 77
12	78	85	72	.03	1874..... 81    1879..... 81    1884..... 79    1889..... 76
13	79	85	73	.28	1875..... 80    1880..... 80    1885..... 82    1890..... 81
14	82	89	74	.03	1891..... 81
15	80	87	74	.03	Total excess in temp'ture during month, 12.
16	81	86	76	.37	Total deficiency in temp'ture since Jan. 1, 42.
17	76	84	68	.50	Prevailing direction of wind, S.
18	72	79	66	2.08	Total movement of wind, 5070 miles.
19	80	89	71	.02	Extreme velocity of wind, direction, and date,
20	82	89	76	0	38 miles, N., 17th.
21	84	90	78	0	Total precipitation, 4.45 inches.
22	83	89	77	T	Number of days on which .01 inch or more of
23	84	93	75	0	precipitation fell, 14.
24	82	94	70	.54	TOTAL PRECIPITATION (IN INCHES AND HUNDREDTHS)
25	84	91	78	.12	FOR THIS MONTH IN—
26	82	88	77	0	1871..... 8.61    1876..... 6.20    1881..... 2.84    1886..... 0.30
27	82	90	75	0	1872..... 5.34    1877..... 2.75    1882..... 2.07    1887..... 11.33
28	84	93	75	0	1873..... 6.68    1878..... 7.35    1883..... 12.05    1888..... 9.09
29	84	92	75	0	1874..... 9.62    1879..... 2.96    1884..... 8.60    1889..... 7.62
30	85	94	76	0	1875..... 4.92    1880..... 6.43    1885..... 3.30    1890..... 7.71
31	...	...	...	...	1891..... 4.45
					Total deficiency in precip'n during month, 2.32.
					Total deficiency in precip'n since Jan. 1, 13.54.
					Number of clear days, 8; partly cloudy days,
					14; cloudy days, 8.
					Dates of Frost, .....
					Mean maximum temperature, 88.
					Mean minimum temperature, 73.

NOTE.—Barometer reduced to sea level. The T indicates trace of precipitation.

G. E. HUNT, *Sergeant, Signal Corps Observer.*

## SYNOPSIS OF SUMMARY FROM SHREVEPORT, LA.

Mean barometer, 29.885.  
 Highest barometer, 30.136, 4th.  
 Lowest barometer, 29.573, 19th.  
 Mean temperature, 81.2.  
 Highest temperature, 97, 21st; lowest temperature, 62, 8th.  
 Greatest daily range of temperature, 26, 17th.  
 Least daily range of temperature, 15, 9th and 13th.  
 Prevailing direction of wind, S. E.  
 Total movement of wind, 4070 miles.  
 Extreme velocity of wind, direction, and date, 40, N. E., 26th.  
 Total precipitation, 1.34 inches.  
 Number of days on which .01 inch or more of precipitation fell, 10.  
 Total deficiency in precipitation during month, 2.35.  
 Total deficiency in precipitation since January 1, 11.91.  
 Number of clear days, 10; partly cloudy days, 16; cloudy days, 4.  
 Dates of frost, —.  
 Mean Max., 91.0.  
 Mean Min., 71.3.

W. J. WRIGHT, JR., *Observer.*

Do not fail to read our Proposition at the bottom of page.

# THE MOST PERFECT ARTIFICIAL INFANT FOOD.

It goes without saying that a child, to be perfectly nourished, should be fed on healthy human milk, or its equivalent, during the nursing period, or at least until seven months of age. If a child under seven months of age **must** be **artificially nourished**,

## LACTO-PREPARATA

is the only Food which meets every requirement, as it is the only perfect **artificial human milk** ever produced; when dissolved in luke-warm water it practically resembles human milk in *composition, character, and taste*.

It is made from pure cow's milk, contains no cereals in any form, and is treated according to the directions of **Prof. Attfield for sterilizing milk**.

**Lacto-Preparata** and **Carnrick's Food** are now put up in air-tight cans **only** and will keep perfectly.

## CARNRICK'S FOOD

is composed of two-thirds of **Lacto-Preparata**, and one-third of dextrinized wheat, and is more especially intended for children from seven months to two years of age.

### A PROPOSITION TO ANY PHYSICIAN.

\*The flesh of all children fed *alone* on **Lacto-Preparata** or **Carnrick's Food** is *firm* and *solid*, because they contain the requisite amount of *albuminoid constituents*.

The flesh of all children fed alone on any other Milk Foods (containing as they do 90 to 94 per cent. of cereals), is soft and flabby, because they do not contain sufficient nitrogenous elements, and the children thus nourished will in consequence quickly collapse when attacked with any serious complaint.

*We respectfully request Physicians* who are prescribing these Foods to examine the flesh of the Infants and verify our statements.

We are so confident that our Foods are practically perfect as substitutes for healthy human milk that we will furnish gratis to any Physician who is now prescribing other Foods or cow's milk, sufficient of our preparations to enable him to judge of their dietetic value in perfect nourishing qualities, as compared with other foods for similar purposes.

REED & CARNRICK, MANUFACTURING CHEMISTS,

NEW YORK.



# SYR. HYPOPHOS. CO., FELLOWS.

Contains the Essential Elements of the Animal Organization—Potash and Lime;

The Oxidising Agents—Iron and Manganese;

The Tonics—Quinine and Strychnine;

And the Vitalizing Constituent—Phosphorus; the whole combined in the form of a Syrup with a Slightly Alkaline Reaction.

It Differs in its Effects from all Analogous Preparations; and it possesses the important properties of being pleasant to the taste, easily borne by the stomach, and harmless under prolonged use.

It has Gained a Wide Reputation, particularly in the treatment of Pulmonary Tuberculosis, Chronic Bronchitis, and other affections of the respiratory organs. It has also been employed with much success in various nervous and debilitating diseases.

Its Curative Power is largely attributable to its stimulant, tonic, and nutritive properties, by means of which the energy of the system is recruited.

Its Action is Prompt; it stimulates the appetite and the digestion, it promotes assimilation, and it enters directly into the circulation with the food products.

The prescribed dose produces a feeling of buoyancy, and removes depression and melancholy; *hence the preparation is of great value in the treatment of mental and nervous affections.* From the fact, also, that it exerts a double tonic influence, and induces a healthy flow of the secretions, its use is indicated in a wide range of diseases.

## NOTICE—CAUTION.

The success of Fellows' Syrup of Hypophosphites has tempted certain persons to offer imitations of it for sale. Mr. Fellows, who has examined samples of several of these, *finds that no two of them are identical*, and that all of them differ from the original in composition, in freedom from acid reaction, in susceptibility to the effects of oxygen when exposed to light or heat, *in the property of retaining the strychnine in solution*, and in the medicinal effects.

As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, physicians are earnestly requested, when prescribing the Syrup, to write "Syr. Hypophos. **Fellows.**"

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles; the distinguishing marks which the bottles (and the wrappers surrounding them) bear, can then be examined, and the genuineness—or otherwise—of the contents thereby proved.

*Medical Letters may be addressed to:*

Mr. FELLOWS, 48 Vesey St., New York.

September, 1891.

*Pantheum sepulchre distat inertie  
Celata virtus.—HORACE.*

New Orleans  
Medical and Surgical  
Journal.

Augustus McShane, M. D.,

Editor and Publisher,

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# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

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## Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the first day of the month preceding that in which they are expected to appear. A complimentary edition of twenty-five reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a written order for the same accompany the paper.]

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### DISSEMINATE PARASITIC PERIFOLLICULITIS.

By A. H. OHMANN-DUMESNIL.

Professor of Dermatology and Syphilology in the St. Louis College of Physicians and Surgeons.

After a pretty thorough examination of the principal works on dermatology, which pretend to be complete treatises, I have failed to find mention of a group of symptoms observed by me a number of times. The constant presence of certain well defined lesions, accompanied by the same subjective symptoms has led me to look upon it as a distinct disease; and it is on this account that I take the opportunity of describing it, choosing as a name (for want of a better appellation) *disseminate parasitic perifolliculitis*. It shares somewhat in the nature of sycosis and seems to resemble the bacillogenic form more than any other, on account of its superficial character and the readiness with which it yields to therapeutic measures which are applied in a rational manner.

A brief description of this trouble may be summarized as follows: The first symptom noticed is a burning of the skin, accompanied by more or less itching. An examination of the affected part shows that small red macules, of the size of a pin's head, more or less aggregated, are present. In the centre of each one of these macules is a rather coarse lanugo

hair. The color of the macule is a bright red, closely bordering upon the scarlet and suggesting an acute inflammatory process. In a short time, varying from forty-eight hours to three or four days, the character of the lesion changes. It becomes yellow in color, painful to the touch, and itches more. If a hair be extracted or the epidermis be punctured a drop of pus exudes. It has become distinctly pustular. Scratching opens the pustules easily and readily, and the contained pus is found to be of an auto-infectious character. If the patient scratches the affected, and then the unaffected parts, the latter become infected and the seat of a similar process.

The portions most often affected are the anterior surface of the thigh, of the leg, the chest, the axilla, and the dorsum of the hand. In the majority of the cases it is upon the anterior surface of the thigh that the disease is first observed, consisting of a few macules. The eruption becomes rapidly disseminated and it may be found upon any portion of the integument which is supplied with coarse lanugo hairs. While I have observed it in all such localities, I have also noticed it in the axilla and upon the chest, regions supplied with coarse hairs; but never upon the scalp, face or pubis. However, it would require for the observations to confirm the fact, if it be one, that these regions are exempt.

As the lesions become more numerous the itching increases, as also the pain. This latter becomes so great, at times, that I have seen it confine a patient to his bed, he being utterly unable to walk on account of it.

A curious condition which I have also noted is that all the patients whom I have seen affected with this trouble were males and adults. Children and females do not seem to contract the disease, in my experience.

Before proceeding any further, I desire to give a short history of a few cases, illustrating different forms of the disease:

CASE I.—John B., a laborer, aged 48, applied for treatment for a pustular eruption upon his right hand. The dorsum, near the thumb and extending to the wrist, was involved, the entire area being about two by two-and-a-half inches. In this space each hair forced a small collection of pus, the size of a small lentil. There was no elevation of the lesions present.

Œdema of a rather marked character involved the entire dorsum of the hand. The trouble had lasted two weeks and had gradually spread to the size it had when observed. Pain was quite marked, and the itching not so much that it could not be allayed without much difficulty. The patient's habits of cleanliness were fair, and no history of a particular irritant coming in contact with the hand could be made out. The man was still engaged at work but it caused him increased pain.

CASE II.—M. S., aged twenty-eight; commercial traveller. In this case the patient was provided with a strong growth of hair upon the chest and thighs. He complained that for nearly a month he was troubled with marked itching of the anterior portion of the chest, and of the axillæ. Upon examining him but few pustules were found, some existing in each one of the portions complained of as pruritic. There was no particular pain present. The progress of the trouble had been gradual and slow, having begun upon the thighs. The entire process seemed to be rather benignant in nature, and occasioned but little discomfort beyond the itching, which became intense at times. The rapid amelioration and disappearance of the trouble were confirmatory proofs of its benign nature. One point, which must not be forgotten, was the scrupulous cleanliness of the patient. This may have had some influence upon the spread of the disease, retarding it to some degree, and making its intensity considerably less than it otherwise might have been.

CASE III.—G. S., an employé in a city institution, 47 years of age, applied for the relief of what he had been told was "blood-poisoning." The eruption in this case was interesting from the fact that in addition to the lesions of the disease, there was marked erythema of the integument. The lesions consisted of a number of small, bright red macules, throughout which were flat, pin-head sized pustules, each one of which was traversed by a hair. The itching was marked, the pain being of a rather acute character, and attended with periodical exacerbations. The locality implicated was the anterior surface of each thigh. The diffuse redness or erythema had a rather dark tinge, as if it had existed for some time, so that the macules of the cutaneous trouble stood out in



a well-marked manner. The erythema was, without doubt, the result of irritant applications which had been made to the surface, the nature of which was entirely unknown to the patient. The fact that the erythema came on after their use and disappeared upon discontinuing them, would lead to the inference that the reddening was produced factitiously and did not constitute a variation in the original process.

CASE IV.—This case occurred in a young man of 35, of good physique, with a well-developed pilous system. His general health is good. He is swarthy in complexion, and well designed, apparently, to resist any parasite invasion, and yet he presented the most severe case of the trouble that I ever saw. Dr. A. C. Robinson, of this city, requested me to call on the patient, whom I found in a pitiable condition. His left leg, from the ankle up to the groin, was one mass of pustules, each one traversed by a hair. The size of these lesions varied from a pin's head, to a gold quarter dollar. They were all flat and the intervening portions of integument had taken in a bright red color, this being due to the high grade of inflammation which was present. The interior and a portion of the lateral aspects of the thigh and leg were the portions implicated. The right leg was also the seat of the trouble as well as the thigh but to a lesser degree. His right fore arm, right axilla, and right side of the chest were quickly implicated, the left arm being free and the left side of the chest having but a dozen lesions at the most. The itching was of a pronounced type and the pain in the left leg so intense that the patient could neither bend it or support his weight upon it. It was tender in the extreme; and the pain was such at the time I saw him, that he had passed several sleepless nights. In addition to this there was loss of appetite and considerable depression.

The cases I have rapidly sketched represent types of this affection, which seems to be, clinically, a sycosiform disease, and, like certain forms of sycosis, dependent upon microorganisms. The chief characteristics to be noticed are that the lesions rapidly become pustular, a well marked amount of pus being present in each. The preliminary redness which exists shows that the trouble is not so very rapid, as the erythema may exist several days before any puriform condition is estab-

lished. The pus collects around a hair and does not elevate the upper layers of the epidermis, but has a tendency to spread laterally. That it is a perifolliculitis, is evidenced by the fact that hairs which are extracted do not show any structural changes; and, after the process ceases, they have the same appearance that they had before.

Another peculiarity of the affection is that it generally begins upon the anterior surface of the thigh and is found there in almost every case. Case I, given above, is the only exception which I have seen.

The subjective symptoms are mild or severe in direct ratio to the severity of the disease. If the process be severe we have added to the pruritis a new element, that of pain, which may become exceedingly intense as in Case IV. As a rule, it is the itching that is constantly present.

The parasitic nature of the trouble is established beyond doubt in my mind, although I have had no opportunity of studying the microorganisms in this disease, nor even of verifying their existence by means of cultivations and inoculations, a task which I propose to accomplish ere long. My reasons are purely clinical in character, but they are sufficiently strong to make the basis of a good argument. In the first place, the auto-infection which takes place is undoubted. In Case IV, for instance, the disease was well established upon the left leg before it appeared in any other locality. The patient used his left hand principally to scratch with and thus infected his right leg, right forearm, axilla and chest. In other cases which I have seen, patients stated that they had scratched certain parts without any apparent reason, and these soon became infected. The infection, however, did not spread beyond the area which was scratched, and this is further proof of the manner in which the infection took place.

That the process is a superficial one is shown by the appearance of the lesions, and by the rapidity with which they yield to treatment rationally applied; that the cause is a microorganism goes without saying; and, judging by analogy, as exemplified in sycosis, by Unna, the special microorganism should certainly be a bacillus. Bacilli, in sycosiform affections, have a tendency to act superficially, the deeper involve

ments being caused by pyogenic micrococci. The absence of any marked implication of the hairs as well as the healthy condition of their bulb, points certainly to a superficial action. Bacteriological investigations, of course, will alone determine this point with sufficient accuracy to be satisfactory and positive.

The treatment of this affection has been simple and eminently successful. Of course, the first thing to do is to get rid of the pus, then prevent further suppuration, and finally encourage as rapid a *restitutio ad integrum* as possible. In order to obtain these results I have adopted the following method of procedure: To get rid of the pus, the best method is to puncture each pustule. Epilating will accomplish the same result, but it is too painful. As the hair bulb is not diseased, the pulling out is attended with pain, and when we have superadded to this the inflammatory condition of the parts, it can be easily understood that patients will protest vigorously against such a method. So that, under the circumstances, the evacuation of the pus can be affected in a better way by opening each pustule with small, sharp knife.

In order to accomplish the other two objects, parasiticides are necessary, and a number of methods may be employed. It would be difficult for me to state which one of those I have employed is the preferable, all having acted rapidly and satisfactorily. Not having a sufficient number of similar cases at any one time, comparative tests were out of the question. The methods I employed were few in number, and I restricted myself to their use, hesitating to enter into a *terra incognita* when I was certain of having a firm foothold upon which I could depend. Altogether, I rely upon three methods, each one of which is as good as the other so far as I know. There may be others which are superior, but the principle remains the same, the particular application depending, in a great measure, upon the individual.

One method which is very simple is to order the application of campho-phenique to every portion of the affected surface. The pus, as in every method, should have been previously evacuated as stated above. The surface should be kept



continuously moistened with the remedy, and a rapid result is obtained.

A second method is to wash the affected parts twice daily with a 1-500 bichloride solution, taking care not to do more than dampen the skin with the solution. A thin layer of an ointment composed of aristol, one part, and *fresh* unguentum aquæ rosæ or unguentum pomadinum, is applied immediately after each washing.

A third method is to employ a 1-500 bichloride solution as above, and a bichloride ointment of the same strength. This method is more particularly applicable to small, limited areas as in Case I. If applied to large areas there might be some danger of producing toxic effects.

I have never tried pyocetanin, for the reason that it stains in such a marked manner that patients positively refuse to employ it.

All the different methods of treatment, which have been mentioned, were successful, not only in arresting the disease, but also in bringing about a rapid return to the normal. The applications were all made as thoroughly as possible, and the utility of this procedure was demonstrated by the absence of any relapses. In view of this fact, it is not positive whether the disease is prone to relapses or not. Yet, considering the manner in which it progresses, the high degree of infectiousness possessed by it, and its restriction by anti-parasitic measures, it seems reasonable to conclude that under insufficient treatment relapses would occur.

---

#### MALARIAL HÆMATURIA.

By BRUCE M'VEY, M. D., ELLA, TEXAS.

Black jaundice, as it is known in this country, is a very fatal disease, but fortunately not very frequent; at least not as frequent as it was a few years ago. There was a time, how-

ever, when it was unknown in these parts, notwithstanding there was more malaria, or malarial affections, then than now. As well as I can get at it, it made its appearance in this country along the Brazos and Colorado rivers, in the year 1868 or 1870, and run a very severe course for more than ten years, affecting more or less of the white population every year; most of our male adults, less frequently women and children, and never negroes of either sex or any age. It seems to occur most frequently between the ages of fifteen and thirty years, and in the late summer and early fall months, but may occur at any age or at any season of the year.

It is usually ushered in by a chill, followed by a fever of 102 to 104 deg. F.; pulse variable. Colicky pains over the abdomen, severe lumbar pains, and sometimes pains over the chest, with irritable cough and expectoration of blood, somewhat similar in appearance to fluid extract of licorice, only it was more grumous. To better illustrate it, I will relate a case of this kind. In September, 1889, I was called to see J. C., an Italian, about 28 years old, who, as I was told by the messenger, had pneumonia. I thought it was a little out of season for pneumonia, but said nothing, and waited to see. On reaching the place, I was shown into a little, dirty, hot apartment that was almost suffocating—there a man lay as yellow as a pumpkin—literally a yellow man; his conjunctivæ were yellow, and the fur there was on his tongue had a yellow tinge. I was then shown a vessel containing about a quart of black fluid which he had passed from his bladder, and a rag covered with black sputa, and while I sat there he expectorated more of the same character as that shown me, and which was easily distinguished from the rust-colored sputa of pneumonia. The diagnosis, thus far, was black jaundice. I then proceeded to make physical examination, take temperature and pulse. Temperature was 103 deg., pulse slow and full. Examination of this man convinced me that he had neither pneumonia nor consumption to account for the character of the sputa, so my only conclusion was, that the blood had oozed through the bronchial mucous membrane, and assumed this peculiar character before being expectorated.

The patient had intense thirst, which, he told me, had

not been appeased for several hours, neither had he eaten anything for several days, as he had been having chills and fever, with nausea and vomiting, so that the sight of food was disgusting to him. His teeth were coated with sordes, and his breath was very offensive.

I ordered cold water to be given in sufficient quantities at short intervals, and notwithstanding he was experiencing some difficulty of breathing, I injected 15 drops of fluid extract *juborandi* hypodermically, without the slightest increased trouble of respiration, or any perceptible increase of salivation or nausea; but within ten minutes from the time of the injection he was covered with perspiration, and in a very short time his temperature was down to 101 deg., and his general condition somewhat improved. I then gave him 15 grs. of calomel with  $\frac{1}{4}$  gr. of podophyllin, made into three powders; gave one every two hours, followed by 5-gr. doses of sul. quinine every four hours with 30 drops sweet spirits nitre half-way between (alternately). His bowels moved freely, and the next day he was much improved, but on the day following he had another paroxysm, though not so severe as the first, after which he made a slow but gradual recovery, on no other treatment than a tonic of iron, quinine and nitric acid, interspersed with a little toddy.

One must not suppose, however, that all cases are so amenable to treatment as this, nor is there any routine treatment. The treatment is symptomatic, and the symptoms are variable; as some one has aptly said, "if there is anything regular about black jaundice, it is its irregularities." All the symptoms that have been mentioned as belonging to the disease are not constant, though enough of them will always be present to avoid error in diagnosis, and as to treatment, I consider calomel and quinine in most cases necessary, and sometimes in enormous doses; I have given as much as 100 grs. of calomel in thirty-six hours. To make a long story short, the treatment consists in keeping all the sewers of the body open, sustaining the patient, and using an anti-periodic.

This, in my opinion, is best done by a free use of mercury and quinine, and mildly acting diuretics and diaphoretics,



and as much cold water as the condition of the stomach will allow, with a light, nourishing diet, and stimulants as needed.

Now, having seen that this malarial hæmaturia is most prevalent in malarious districts, and is treated on the basis of a malarial disease, the question arises, is it due to malarial infection? Strictly speaking, no. While malaria plays an important part, and is the chief factor, no doubt, I can not believe that it is the sole cause, for if it were, why should people not have had it before they did? for there were just as many or more cases of chills and fevers and other diseases due to miasmatic poison then than now. Some doctors say that it is due to the use of quinine; that at an early day there was little quinine used, consequently, no black jaundice, but that will not do, for I have seen cases that had not taken a dose of quinine for twelve months previous to the attack; furthermore, where is there a place where more quinine is used than in and around New Orleans? and there is little or none of the disease in question to be seen. And again, if quinine had any causative influence, why is the disease declining, when quinine is being used all the time?

I believe there is some specific germ that finds a congenial home in the poisoned blood of those living in low, damp districts, and as soon as that condition is removed by appropriate means, the germ ceases to thrive and the patient is cured. I have never seen a case that was not preceded by a so-called bilious attack of several days, weeks or months; perhaps not chills and fevers, but vomiting of bile, malaise, or other concomitant symptoms.

Now, it may be asked, to what is the decline of the disease attributable? I would answer by saying to a decline in the suitable subjects. There is not as much intermittent and remittent fever and other affections of the kind now as formerly, and this, I think, may be attributed to the condition of the soil, water supply, etc. It used to be that there was not so much land clear, and what was clear, for the most part, was freshly cleared and badly drained, and there was, consequently, a great deal of decaying matter. The timber not being cut off the land, there was but little inlet to breeze, which made it very uncomfortable during the warm months of the year. Now

there is great deal more land clear, and it is better drained; the surface wells and lagoons are supplanted by the artesian well and the cistern.

1. Malarial hæmaturia is a disease from which recovery is slow, and relapses frequent. In order to guard against relapses, the patient should be kept in cool, comfortable quarters, and all undue excitement, indiscretions of etc., avoided.

2. It is a disease that is liable to recur, one attack seeming to predispose to another.

3. Suppression of urine sometimes occurs, and is a very grave symptom; if the urine should fail to be voided, make use of the catheter, for the urine is sometimes retained.

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#### ANENCEPHALOUS MONSTROSITY.

BY DR. HUGO A. GABERT, NEW ORLEANS, LA.

[Read before the Orleans Parish Medical Society.]

*Mr. President and Gentlemen:* I hereby present you a report of a case of labor, showing the difficulty that may confront us in making a diagnosis of the presentation.

The patient under consideration, Mrs. B. V., is 38 years old, white, a native of New Orleans, thirteen years married, during which time she has had six children—the present one included—and one miscarriage; is of a rather slender figure, dark complexion, and weighing about one hundred and ten to fifteen pounds, proportionately well built; had been unwell in the beginning of December last, and consequently expected her confinement in the early part of September next.

Sunday morning, July 19, at a quarter to 1 o'clock, Mr. J. V. roused me out of my sleep, requesting me to go with him and relieve his wife, who was suffering unbearable pains. Some medicine had been administered to her by one of our confrères, but without giving the desired relief.

I hesitated, but the gentlemen insisted that I should take charge of his wife during her confinement, having had the lady under my care before.

On entering the house I found the patient walking the floor with an abnormally distended abdomen (her relatives expecting to see twins), saying: "I have been suffering since last Sunday, and can't stand it any longer. I have had no sleep, and no rest for a week."



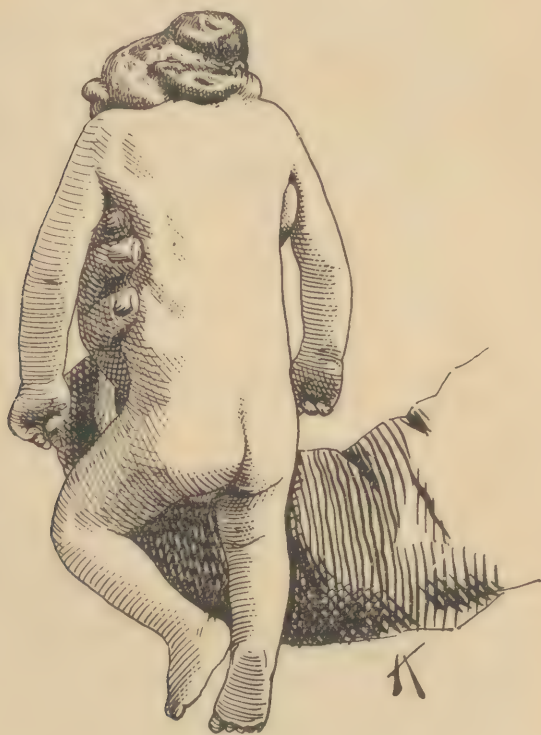
From continuous contraction the uterus had become so hard and tense that the abdomen did not yield, and palpation for fluctuation and auscultation for the fœtal heart-beat resulted in the negative.

Upon digital examination, found the neck of the uterus not yet gone, but rigid and tough as sole leather, the opening of the external os was three-quarters of an inch in diameter, large enough to admit a finger. I made forcible dilatation in



order to be able to make a thorough examination, which, instead of increasing the pains, gave her decided relief.

The introduction of my finger revealed a feeling of a bony substance like that of the posterior fontanelle, but floated away as soon as I touched it, and I perceived a most excellent ballottement; the membranes were intact, although the patient had complained of losing small quantities of water during the week. After the conclusion of the examination, I told Mrs.



V. that the parts were not ready for delivery just now, but that the incessant pains would certainly tend to bring on labor. Administered one-half of a grain of morphine hypodermically, and in one hour from my arrival at the house, left Mrs. V. quite comfortable, and at the same time left a prescription of chloral hydrate, ten grains to be given every two hours in case the pains should continue in their severity.

At my morning visit, found the patient in good humor and

almost without pains, had not taken any medicine during the interval, did not sleep any but felt easy all night.

The uterus presented about the same condition as the night before. I felt some fœcal matter in the rectum, therefore ordered Rochelle salts and cream of tartar aa  $\mathfrak{z}$ ij, to be taken a tablespoonful every three hours in water until the bowels were freely open. Monday morning, at the same time as the night before Mr. V. came after me again, saying that his wife commenced to suffer more than ever since 11 o'clock, attributing the pains to the effect of the powders; but upon digital examination found Mrs. V. to be in an advanced stage of labor, the os now being open to the extent of about one inch and a half in diameter, the uterus still very rigid. I felt the same bony substance as before and ballottement, and took it to be an accidental presentation; the sac was still intact and presented the same round formation which is usual in such cases. After waiting about one hour, during which time Mrs. V. had good pains, I ruptured the membranes with my fingers; when down came the water in torrents; I thought there would be nothing left of my patient; this was certainly a case of dropsy of the amnion, which condition now accounted for the negative result as to the fœtal heart. When the water had all been drained out, the abdomen appeared completely collapsed, but Mrs. V. felt quite comfortable, about the same as a person who has been relieved of an over-distended bladder.

When I examined the parts again I found a different state of affairs, felt for the rotundity of the head, but could not find it, looked for the fontanelles with the same result; but instead I felt a mass, round in shape, about the size of a good sized scrotum, and everything around felt soft and mushy, and everything pointed to a breach presentation; that bony piece might have been the coccyx; there was a depression which was similar to an anus; and I felt for the penis but could not find it. Surveying the whole situation, I must confess that I was completely perplexed.

I gave up all knowledge as to what presentation was before me, and concluded to wait for the arrival of the curiosity. Mrs. V., having had good pains, in the meantime she expelled the contents of the uterus in about half an hour, when, to my

still greater astonishment, I perceived with a most horrible feeling, a living anencephalous monster of a seven and one half months' gestation; the mother naturally asked about the condition of the child, when I explained as gently as possible what had happened, and that it was best for the child not to live. It was otherwise well developed, but quite rigid and breathing and kicking. I turned it over on its face, and it lived about ten minutes. I did not show it to the mother. The mother had no disagreeable symptoms after the birth of the child, not even an iota of after-pains, no fever up to July 28, when she sat up in bed; the lochial discharges have become scanty and of a pale color, so that I consider her in a normal condition.

The accompanying drawings, from photographs, will give an accurate idea of the character of the monster.

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### MEDICAL JOURNALISM.

By JOHN CLARK LEGRAND, M. D., Anniston, Ala., Junior Counsellor of the Medical Association of the State of Alabama.

I shall not expect you, whom I address, to put yourself in my place and view the subject of medical journalism from the standpoint of an editor; but rather, I think it wise, that I should occupy the general ground of professional interest and pride, and with the highest good of the profession, and the deepest interest therefore, in the success of every worthy physician and helpful theory, actuating thought and expression, discuss this subject in that manner best calculated to advance the important and dignified cause we represent.

Perhaps we may not be agreed as to the details of clement combination and policy which will go to make up the highest conception of professional journalism, and it is probable that no one of us could originate a journal, embracing all the in-



dividual preferences of this body, but it is safe to assume, in the light of experience and observation, that a profession representing so much intelligence and ability as ours, and one in which the members bear such vital relations one to another and the people, should have a medium of communication such as can be found only in journalism, and regardless of individual ideas and preferences, that journal is the best that most nearly and truly represents the progressive sentiment and development in our profession.

Medicine has always been an honorable and respected calling, and the vital relationship sustained to the people, and the confidence imposed in those who assume the obligations and responsibilities of physicians, demand the prosecution of every line of development and discovery, and the use of every possible means of knowledge in the accomplishment of the most good and the attainment of the highest success.

There may be basic truths that were just as clearly known a century ago as now, but the man who follows now the methods of fifty years ago, will soon find himself without patients or fellowship, and we may with much profit take a lesson from other fields of activity.

The same principles hold good now that have ever been true as to the germination of the seed, the springing of the blade, the growth of the stalk, and the perfection of the ear, but the farmer who has not risen above the plane of fifty years ago as to the implements used and the methods followed, will soon drop behind in the march of agricultural progress and improvements. Every live farmer take an agricultural paper, and the benefits from so doing are evident in the improved stock, diversified crops, and more respectable appearance of the farms of our land, and it is also true that this class, who were once considered unfit for legislative and kindred duties, are coming largely into the control of state and national affairs, and in the accomplishment of such results, journalism has been an important factor.

In the political field, journalism is a power so far reaching and effective, that the best talent and enterprise of the land are brought into command and exercise for the dissemination and cultivation of party principles and methods.

Years ago, a paper once a month or once a week, at least, from headquarters, was considered sufficient, but now we read the enterprise and success of political parties in mammoth dailies that chronicle with wonderful quickness the news of the world.

Every religious denomination of any importance, quick to see the advantages offered, has entered the journalistic field, equipped with the best talent at command, and so efficient has been this factor of evangelization, that a denomination without a state journal, is considered lacking in the characteristics of enterprise and diligence; and so great has been the demand for the work, that journalism alone can accomplish, that every respectable order, union, and association has its organ, and in most cases, state papers and journals. But in no other way, perhaps, has journalism more clearly shown its power and usefulness, as in the part borne in the development of the resources of the country.

The custom of organizing land companies for the development of particular locations and resources has largely obtained of late years, and the good thus done is incalculable, and the advantages offered in a paper for bringing the possibilities and prospects of a place to the knowledge of the people have been quickly recognized, and no one factor has, perhaps, done or is doing so much in the work of developing our southland.

Every city and town of any consequence has its paper or papers that go forth as the representatives to attract the attention and bring the help of such as are qualified to assist in the forwarding of industries and the development of resources.

And what is true of the agricultural, the religious, the political and financial world, in so far as journalism becomes a helpful factor in the advancement of the several interests represented, is eminently true of our profession, which in intelligence, ability and possibilities is second to none, and therefore we can not, without great injury to ourselves and to our cause, be indifferent to the opportunities offered us for the attainment of knowledge that comes only through this channel, and we would be unpardonably recreant to our high duties were we wanting in the enterprise necessary to retain our place in the front rank of the profession, and our journalism may well and

justly be taken as an exponent of professional enterprise and progress.

But let us glance at a few of the practical and active benefits of journalism to our profession. First, a journal which represents the results of the research and discovery of the medical world, puts the reader at once in touch with the hearts, purposes and accomplishments of all who labor for the good of the cause of cure and prevention, and further, the publication of any theory by a reliable and accredited journal brings such theory to the attention, scrutiny and consideration of the master minds of earth, and thus opportunity is given for the vindication of truth and its application in helpful practice which might otherwise have scarcely become known in a hundred years, and on the other hand, errors which the evil-minded, and the charlatan might use for the damage of physicians and patients can be exploded.

Other than strictly medical journals might publish these things, but so limited, unsatisfactory, unauthorized and erroneous would, in all probability, the publication be, that much harm would result.

And if we are to benefit by the work and progress of our medical brethren and co-workers in the field of practical and scientific effort, we *must* have an organ of communication and information that is reliable and authoritative, and this we can have only in a journal that is distinctly representative in character. Another feature of especial importance is the fact that in unprofessional journals, no bar is fixed as to fitness for discussing the subject in hand, and it is often the case that writers are absolutely ignorant, or sinfully vicious, and the results of such are seen in the false notions and prejudices that abound in the public mind, and give trouble to honest practitioners and retard curative means. A journal authorized and sustained by the qualified intelligence and influence of accepted physicians and cultured scholars, is authoritative and educative in an eminent degree, and through this medium we hold converse with the leading minds of our profession as they deal with the practical, ethical and scientific laws, principles and influences that govern, sustain and elevate the interests we represent.



Many men of fine ability and rare attainments, who shrink from notoriety through the public press, speak to us through the columns of a professional journal, and we are thus brought into active harmony with the moving spirit of the age, and keep abreast with the onward march of the medical mind.

And in this connection, worthy of mention, is the fact that medical manufacturers, importers and publishers, whose goods are meritorious, do not care to descend to the level of the quack, as he sports his flaming advertisement in every paper, good, bad or indifferent, that will give him or his nostrums notoriety for pay, but such will gladly avail themselves of the opportunity offered in an authorized journal to bring their goods to the attention of worthy physicians.

Moreover, journalism has been a most potent and happy factor in bringing about the marked improvements in the courses of study prescribed, and methods of instructions used in our medical colleges. In its nature free and aggressive, and being a means of direct communication between the spheres of practical and experimental life, and that of theoretical and abstractive preparation, the field and the college, the practitioner and the student, are brought near together, and an alliance is formed, out of which have grown studies and methods more in keeping with the conditions and requirements of actual practice. Without this medium it would have taken decades to have accomplished what has been done in a few years.

But suffer a few thoughts in reference to a State journal.

As before said, we are second to no other State in medical talent, ability and efficiency, and while we should cherish and cultivate an appreciative disposition for all our fellows in the profession, the necessity for a closer union of those who are most nearly governed by like conditions of climate, disposition and circumstances, is obvious to the discerning mind.

This is an age of quick and practical treatment and results, and there is little time for experimental uncertainties on the part of live practitioners. We need to pass out beyond the plane of petty jealousies and competitions, into the dignified field of professional honor, helpfulness and progress, and freely converse as to the best methods to pursue to attain the

most satisfactory results for our own good and that of suffering humanity.

Every other progressive profession has been quick to seize upon the advantages offered in authoratative communications and professional interchange of views, and the results of such a course are visible in the active unanimity and growing strength and influence of every such organization, and what is true in this respect of professions in general is conclusively true of ours, and should we lag in enterprise or be wanting in harmony, our claim to leading talent and skill would become as a sounding brass and tinkling cymbal. But so long as our desires are in the direction of a more happy and dignified proficiency in all the phases of our professional life, we will need the help that can come only through an association of such purposes and operations as are found in every worthy disciple of Esculapius, and the comparison of those experiences and observations that are the product of an active and honorable practice.

To my mind the only efficient medium of such communication and enterchange as would be profitable in state journalism, and, if you please, I mean that character of journalism that is truly and broadly representative, and worthy to become a vehicle for the transmission of the ripest thoughts of the best minds of the age, a state journal bearing upon its own heart the good of the profession, and warm with the sentiments and experiences of those who labor day and night in the cities, towns, villages and country districts of our beloved state for the cure of disease and the preservation of life.

In such an enterprise, while the money may be necessary in a certain degree, its life and character would rather receive impetus and shape from warm hearts, thinking minds, active experiences and ready pens.

No state journal can succeed unless the physicians of that state make it their paper in spirit and usefulness in subject matter, and take a pride in its welfare that places it on the high way of professional support and success.

Finally, the past has a history of which we are proud, and the present is pregnant with possibilities that each succeeding day and discovery will develop toward the birth of a happier

day in which falshood and uncertainties shall fade away before the beauty and grace of the opening light of truth.

In this desired consumation, if we do not our part, another will wear our crown, but I feel the movings of a nobler spirit than would be guilty of indifference.

With a unanimity born of the highest aspirations, a proficiency that is the product of truth and culture, we are moving toward the highest plane of professional attainment possible to man, confident that the great Physician, the master of us all, shall give to us that are worthy a fadeless crown of eternal healing.

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## Hospital Reports and Clinical Notes.

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### HOSPITAL FOR WOMEN AND CHILDREN.

#### PAINLESS LABOR.

DR. E. DBNEGRE MARTIN.

Mrs. S. S., white, æt. 20, primipara, was admitted to Hospital for Women and Children June 4, 1891. Patient expected to be confined about June 20. On morning of June 9 patient complained of cramps in the abdomen. My attention was called to the fact at 3 P. M., and to guard against a surprise I determined to make an examination to ascertain if labor might not be progressing. Much to the surprise of both myself and the patient I found the os fully dilated, the head presenting and in the first position. There was complete inertia of the uterus. Administered 10 grains of quinine, which patient vomited. Half hour later administered 15 grains. In three-fourths of an hour slight contractions of the uterus were apparent, but patient suffered little if any pain. Membranes were ruptured, and in half an hour patient was delivered of a 6½ pound boy baby. Slight hemorrhage followed after delivery; this was checked with hot water douches. No further trouble occurred, no elevation of temperature, nor was the patient aware of any after-pains. Said she had suffered more from constipation than from the birth of her child. The placenta weighed ¾ pounds; the umbilical cord was 41 inches



long, and was wound twice around the child's neck. There was nothing else abnormal about the labor, and no lacerations. Patient was discharged on June 30. When last seen about one month later both mother and infant were doing well.

### LARGE HÆMATOMA OF INFRA-SCAPULAR REGION.

DR. PHILLIP BERGE.

J. R., male; white; age, 18 years; cistern maker. Sent for me on August 11. Began to suffer about two weeks previous; pain in infra-scapular region, steadily increasing with gradual tumefaction of parts involved. Attending physician had been treating patient for neuralgia, with narcotics internally, and a porous plaster externally. No positive traumatism, or cause, could be discovered, except it be that patient's occupation entailed the duty of lifting and throwing a very heavy hammer, made use of in driving down iron hoops on cisterns. Subjective symptoms on the 11th of August: anorexia, pain, insomnia. Objective symptoms: fever; pulse fast and weak, and hectic sweats; swelling involving scapular region, infra-scapular principally, and infra-axillary. No fluctuation at this stage, but skin on a stretch. I ordered side painted twice daily with tincture of iodine, and quinine and opium internally; diet, egg-nogg in generous quantity. Wednesday, August 12, tumefaction lessened in area, but pain increased and localized to a focus on a line a little external to inferior angle of scapula. Ordered hot fomentations; and, a continuance of quinine and opium, and egg-nogg. Thirteenth and 14th, pain somewhat subsided, but fluctuation deep seated suggested to my mind the presence of pus. On the 14th cocaineized parts, and used Dieulafoy's aspirator, and withdrew a little less than half ounce of pus. My immediate conclusion was to cut for pus pocketed beneath the deeper muscles; and, "seance-tenante," a deep incision was made in the tract of the needle, followed by a gush of dark blood, but *no* pus. Cocaine anæsthesia being dispelled, I stopped further exploring; introduced small gauze tent, and dressed wound antiseptically.

Temperature during operation, 101 deg.; same evening at 9 o'clock, temperature 99 $\frac{3}{4}$ ; pulsations less frequent; patient resting easy. Next day, having some doubts as to the true condition of affairs, I called Dr. M. in consultation, who, having detected some more fluctuation, advised the propriety of making a much deeper and larger opening. Under cocaine anæsthesia, my bistouri pursued the same course,

making a wider sinus, with the advent of another gush of dark blood, and to our mutual surprise not the least trace of pus. An ordinary size dressing forceps introduced into the cavity could be opened to the full extent. A large rubber drainage tube was inserted, and wound dressed with iodoform gauze, etc. Next day (16th August), temperature normal; pulse normal, but weak; appetite returned. Ever since patient has been steadily improving in every respect. Dressing changed daily; secretion scanty and without foul smell. The side has resumed its natural appearance.

Diagnosis: Suppurating hæmatonia below Latissimus dorsi muscle, probably caused by rupture of muscular fibres.  
*New Orleans, August 23, 1891.*

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## Proceedings of Societies.

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### MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

OFFICE OF CHAIRMAN OF COMMITTEE OF ARRANGEMENTS, }  
St. Louis, Mo., August 18, 1891. }

*To the Subscribers and Readers of the New Orleans Medical and Surgical Journal:*

The Mississippi Valley Medical Association will hold its seventeenth annual session at the Pickwick Theatre, Jefferson and Washington avenues, St. Louis, October 14, 15 and 16. A full programme of interesting papers has been prepared, and provision has been made for the fullest, freest and most complete discussion of the same. Representative men from various sections of the country have been invited to open the discussions. The local profession of St. Louis is a unit to the end that every visiting physician shall be received and welcomed in a regular warm-hearted St. Louis style.

The same qualifications for membership are requisite in this association as for the American Medical Association, the former being subordinate to the latter. If eligible, you and your friends, together with your wives and families, are most cordially invited to visit St. Louis and enter into the scientific work and the social pleasures as you may desire.

I. N. LOVE, M. D.,  
*Chairman Committee of Arrangements.*

## MARION-SIMS COLLEGE OF MEDICINE.

At a recent meeting of the faculty of Marion-Sims College of Medicine, the dean, Dr. Young H. Bond, introduced the following resolutions, which were unanimously adopted:

WHEREAS, The position taken by this college upon the two questions of "Medical Legislation" and "Medical Education" has been intentionally confounded, and

WHEREAS, Notwithstanding the fact that, at the last meeting of the Missouri State Medical Association, the report on "Medical Education," offered by Dr. McAlester, and having as its central idea a three years' graded course of lectures, was, on motion of your dean, with the aid of the votes of all the members of this faculty then present, adopted, it has been sought to have it appear that this college is not favorable to higher medical education,

THEREFORE, To the end that our position upon the question of medical education be clearly understood,

*Be it resolved*, That after the session of 1891-92 the Marion-Sims College of Medicine will exact as a condition to graduation in medicine of all its students who may not have previously matriculated, attendance upon a graded course of lectures extending over three years.

*And be it further resolved*, That our position upon the question of medical education does not in the least abate or compromise our objection to what we regard as the attempted enactment of unjust, inefficient and class-medical legislation, and that this faculty favors an examining board as the fair and rational solution of the problem of medical legislation, and medical education as well.

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MEMBERSHIP IN THE AMERICAN MEDICAL ASSOCIATION.

This is obtainable, at any time, by a member of any state or medical society which is entitled to send delegates to the association. All that is necessary is for the application to write to the treasurer of the association, Dr. Richard J. Dunlison, Lock Box 1274, Philadelphia, Pa., sending him a certificate or statement that he is in good standing in his own society, signed by the president and secretary of said society, with five dollars for annual dues. Attendance as a delegate at annual meeting of the association is not necessary in order to obtain membership. On receipt of the above amount the weekly journal of the association will be forwarded regularly.



# N. O. Medical and Surgical Journal,

ESTABLISHED IN 1844.

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Articles from physicians are respectfully solicited. All articles, news and exchanges, and books for review, should be sent to the EDITOR, NEW ORLEANS MEDICAL AND SURGICAL JOURNAL. Business communications should be addressed to the BUSINESS MANAGER, NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

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AUGUSTUS McSHANE, M. D.

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DR. F. W. PARHAM.      DR. H. W. BLANC.      DR. A. W. De ROALDES.  
DR. R. MATAS.      DR. JOHN DELL'ORTO.

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## Editorial Articles.

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### SHAKESPEARE'S REPORT ON CHOLERA.

The JOURNAL has been favored with a copy of Dr. Edward O. Shakespeare's voluminous and exhaustive report on "Cholera in Europe and India." This valuable work deserves more than the cursory notice generally afforded to books in ordinary reviews.

It will be recalled that President Cleveland, in view of the danger threatening this country from cholera, appointed Dr. Edward O. Shakespeare, of Philadelphia, as commissioner from the United States to investigate the disease in the countries it was then scourging; namely, certain parts of Europe and India. Dr. Shakespeare received his appointment in the autumn of 1885, and returned to America in about twelve months, during which time he performed a vast amount of useful work, but, unfortunately, with a great sacrifice of health.

In the course of his labors Dr. S. visited Italy, Spain, and India. It is pleasing to note that he was everywhere received with the utmost courtesy by the various officials with whom he came in contact.

After summarizing briefly the history of the scientific commissions sent out to investigate cholera, Dr. Shakespeare devotes

much space to tracing the course of the last widespread epidemic of cholera. A vast amount of information from official and private sources throws light on the various methods by which the unwelcome visitor may gain an entrance. Spain naturally claims a larger share of attention, since that country was one of the greatest sufferers from the last epidemic. Although the labor involving in comprising this part of the report was chiefly one of compilation from various sources, still a great deal of industry and selective ability was required to shape the mass into a useful and systematic whole.

As a necessary condition to a thorough understanding of the question of introduction and spread of the disease, Dr. Shakespeare describes the sanitary arrangements of the localities invaded by cholera in its march. The sanitarian sees things that are usually ignored by the historian and the traveler; but those very things sometimes become our greatest foes, and they must not be overlooked if we would devise rational and effective measures for controlling epidemic diseases. The picture drawn of privies and drinking-pools in the cities visited by the cholera is a saddening one. The minute description of the habitations of the poorer natives in India, and of the poorer classes in Palermo and other Sicilian towns, makes us wonder that the people are able to survive a year's residence among such filth. New Orleans has been much blamed for her backwardness in sanitary reforms; but this is a veritable garden-spot in comparison to the cities and villages visited by Dr. Shakespeare. It is faint praise, however, to say that our city is not as dirty as some of the cities that have suffered from the cholera.

Circular letters, containing a series of questions bearing on cholera, were sent by Dr. Shakespeare to physicians in every place in which the cholera had appeared. Much reliable information was thus obtained; and this, coupled with official government reports, makes a collection of facts upon cholera that will always be of value to students of the subject.

As scientific men, we naturally turn to that part of the report which is of special scientific interest. This more particularly concerns medical men, and yet it is the keystone of the arch, for upon it depends the absorbing question of prevention.

Many writers are quoted, and some of Koch's papers are printed in full.

The chapter on the bacteriology and diagnosis of cholera, would, in itself, be a very valuable book if printed alone. The opinions of all the eminent men who have contributed anything to the solution of a great question, are given concisely but fully. It is noticeable that a large amount of attention is given to Dr. Jaime Ferran, of Tortosa and Barcelona, who performed many inoculations for the prevention of cholera, during the last epidemic in Spain. At the time, Ferran was handled pretty roughly by American writers; but it is pleasing to note that such a competent American critic as Dr. Shakespeare pays a high tribute to his ability as an investigator, and his character as a man.

After quoting freely from the writings of other observers, Dr. Shakespeare furnishes a very fine chapter on his personal observations on the etiology of cholera. This chapter is enriched with numerous illustrations, showing the morphology of the organisms that have been put forward as the causative agents of cholera, and also of the *plasmidium malariae*. The presence of this organism in the blood may be taken as conclusive evidence of malarial infection, and may serve to prevent any mistakes in making a differential diagnosis. The importance of finding this parasite in the blood of a patient with algid symptoms is of the utmost importance in the beginning of an outbreak of cholera. The micro-photographs are Dr. Shakespeare's own handiwork, to execute which he had to learn the art himself. They reflect great credit upon his skill and industry.

The chapters on the bacteriology of cholera form a small encyclopedia of ready reference, giving the gist of all that has been written on the subject.

The subject of preventive inoculations against cholera is fully set forth, and here, of course, Ferran comes in for a large share of attention.

From the reports and correspondence published, it will be seen that while Ferran was a capable bacteriologist, he allowed himself to be led into placing the commercial value of his method before the scientific. A diagram, compiled from



government statistics, shows the relative mortality among those who were inoculated by Ferran and those who were not; the conclusions are certainly very favorable to Ferran's method. Ferran's inoculation fluid is an extract of the culture of the commo-bacillus; Koch's tuberculosis is a fluid prepared in a similar manner from the tubercle-bacilli; and both are simply an elaboration of the method devised by Pasteur, to whom belongs the credit of placing preventive inoculations for infectious diseases on a scientific basis.

Dr. Shakespeare closes his report with sections on prevention and the clinical aspect of cholera. Measures of personal and national prophylaxis (quarantine) are detailed, and all approved methods of combating the disease are fully described. A brief clinical review closes a report that will always remain valuable as a book of reference, and as an exposition of our present knowledge of cholera.

The appearance of the report has been somewhat delayed by circumstances which Dr. Shakespeare could not control. The labor involved in preparing such a report was immense, and all of it was performed without compensation to the doctor. All in all, Dr. Shakespeare's report reflects credit upon the profession of America, and attests the industry and learning of its author.

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TREASURY DEPARTMENT,  
OFFICE OF THE SUPERVISING SURGEON-GENERAL,  
MARINE HOSPITAL SERVICE,  
WASHINGTON, D. C., August 12, 1891. }

A board of surgeons for the examination of candidates for admission into the Marine Hospital Service will be convened at the United States Marine Hospital, St. Louis, Mo., October 12, 1891.

Candidates for examination should make application to the Surgeon General, United States Marine Hospital Service, Washington, D. C., as early as practicable, and should enclose testimonial from at least two reputable citizens, preferably physicians, as to their professional and moral character. No person will be considered eligible for examination whose age is less than twenty-one or more than thirty years, or who suf-

fers from any physical defect which would be liable to impair his efficiency or incapacitate him from duty. The candidate must be a graduate of a medical college of good standing, as evidence of which his diploma should be submitted to the board.

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Messrs. J. B. Lippincott Company announce that they will publish, about September 1, the eighth edition of Wood's *Therapeutics: its Principles and Practice*; rearranged, rewritten, and enlarged. Scarcely three years have elapsed since the appearance of the seventh edition, yet the preparation of the present volume has necessitated a careful study by its author of more than seven hundred memoirs. In the present edition no revolutionary changes have been made comparable to those of the seventh revision, but great care has been exercised to see that every portion of the work has been thoroughly revised, and a number of the articles have been completely rewritten, while some new drugs have been noticed. Among those portions of the book which are practically new may be mentioned, as important, the whole subject of Anæsthetics, the articles upon Cocaine, Strophanthus, Caffeine, Antipyrin, Antifebrin, Phenactin, Hydrastin, Paraldehyd, Lead-poisoning, etc. Among the absolutely new articles may be mentioned Sulphonal, Chloralamid, Aristol, and others.

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## Abstracts, Extracts and Annotations.

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### SURGERY.

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#### THE SUPPOSED CURATIVE EFFECT OF OPERATIONS, PER SE.

Under this title Professor J. William White, of Philadelphia, contributes a paper to the *Annals of Surgery* for August, 1891, which not only from its subject, but from the great number of authorities quoted, and from the peculiarly rich experience of the writer, makes an article of unusual interest and

importance to both surgeon and physician. The author's attention was first directed to the subject by reason of his experiment with the operation of trephining for so-called traumatic epilepsy.

During the past five years, with Dr. D. Hayes Agnew, he has trephined in fifteen cases of supposed traumatic epilepsy. All but one recovered from the operation. The patient who perished was an imbecile, and a confirmed drunkard, as well as an epileptic. Death occurred from suppression of urine, probably secondary to etherization.

In one case a bullet was found imbedded in the brain substance, in another an irregular portion of the internal table was dissected out from beneath the dura mater, to which it was attached by cicatricial adhesions. In another there were projecting spicules of bone on the internal surface of the button removed and the adjacent portions of the skull. In two marked sclerosis and thickening of the cranium were observed about the field of operation. In the remaining cases nothing abnormal was seen. Although this was the case they were without exception markedly improved by trephining; in two instances even to the point of apparent cure, no return of symptoms having been observed for eighteen months, and for two years after the operation. In the other seven the results were strikingly favorable, convulsions disappearing for weeks or months, although previously of more than daily occurrence.

The author has, in so far as this is possible, classified the cases in which operation *per se* seemed to be the main factor in bringing about a cure. These cases are divided into three groups in accordance with the anatomical seat of the symptoms of the supposed disease. This brings them under the following heads:

1. Operations for the relief of nervous phenomena, as epilepsy, insanity, paralysis, etc.
2. Operations for abdominal and pelvic disorders, as peritonitis, tumors, etc.
3. Miscellaneous operations.

This classification is further carried out by grouping together, (*a*) those cases in which nothing whatever was found explanatory of the symptoms; (*b*) those in which some departure from normal conditions was observed, but was so slight as to be apparently inadequate to explain the symptoms; (*c*) those cases in which an apparently grave and irremediable condition was disclosed by an explanatory operation, but notably improved or altogether disappeared after more inspection and handling, no further surgical interference having been thought justifiable.



Under the heading of "Operations for the Relief of Nervous Phenomena," Dr. White has tabulated, including his own service, 154 cases. Many of these are given in detail, and, coming as they do from recognized authorities, are of exceeding great interest.

In fifty-six cases of trephining for epilepsy nothing abnormal was found to account for the symptoms; nineteen cases were reported in six months or less after operation; eleven cases were reported from one or two years after operation; one was reported eight years after operation.

Twenty-five of these cases were reported as cured; eighteen as improved; in three cases it was mentioned that a relapse occurred later.

In thirty cases of ligation of blood vessels for epilepsy, fourteen were reported as cured; fifteen as improved; one died seven days after operation. In the fatal case the right common carotid artery was tied. No fit occurred after the operation.

In ten cases of castration for epilepsy all were reported as cured. One case was reported four months after operation; four cases were reported more than two years after operation; in five the time when reported is not mentioned.

In nine cases of tracheotomy for epilepsy two were reported as cured; six as improved; one as much improved, though death in this case followed in two months after the operation.

In twenty-four cases of removal of the superior cervical ganglia of the sympathetic nerves six remained well at the end of three years; ten were improved; five remained unimproved; two died soon after the operation, but not from its direct effect.

In six cases of incision of the scalp for epilepsy nothing was found to account for the symptoms. Three of these cases were reported as cured at the end of one year; two were reported as cured at the end of two years; two other cases almost similar were reported as cured.

Twelve cases of epilepsy are reported as cured by such operations as stretching of the sciatic nerve, excision of the musculo-cutaneous nerve, cauterization of the larynx, circumcision, application of a seton to the back of the neck, tenotomy of the external recti-muscles, burning of the scalp, puncture of the heart, etc.

Thirteen cases of spontaneous or accidental cures of epilepsy are also reported, at a time varying from two months to five years after the traumatism, which was a fall, a burn, a wound, an amputation, for intercurrent injury of disease, etc.

Passing from the cerebral to the spinal region, Dr. White cites an illustrative case of his own. A man, aged 55, was attacked on December 25, 1887, with severe pains in his arms and shoulders. A few days later there was weakness of the thighs spreading rapidly down the legs to the feet, and upward on the body to the nipple line. In eight days there was an absolute paralysis of the parts involved, including both sphincters, while at the same time the paralyzed parts became the seat of profound anæsthesia. Girdle pains developed, bed-sores made their appearance, percussion of the spine over the third and fourth vertebræ became painful. The reflexes were exaggerated, and light blows on the head in the direction of the spinal axis gave rise to frightful exacerbations of the girdle pains. In spite of every remedial measure these symptoms increased in severity for ten months. An exploratory operation was then undertaken. Dr. White removed the spines and laminæ of the first five dorsal vertebræ, opened the slightly thickened dura, separated some firm adhesions to the subjacent pia matter, explored the cord, and having failed to discover any serious pathological changes closed the wounds in the dura and soft parts.

The girdle pains had entirely disappeared by the following day, sensation began to return in the feet the day after, voluntary motion in the toes after the eighth day, and so one symptom after another disappeared, until the patient completely recovered, and is now earning his living by manual labor.

In the list of abdominal and pelvic disorders apparently cured by operation, *per se*, a number of extraordinary cases are cited. The experience of Tait, who has more than once drawn attention to the astonishing disappearance of tumors, often of large size, after a mere exploratory incision, and the corroborative testimony of Von Mosetig are cited at length. Kœnig's analysis of 131 cases of tubercular peritonitis treated by abdominal incision is carefully discussed.

In response to letters of inquiry upon the subject, Dr. White received many communications from prominent operators, the great majority of them containing notes of cases not previously published.

Among the signers of these letters are to be found the names of Goodell, Hirst, Battey, Roswell Park, Lusk, Cheever, Chas. T. Parkes, Cabot, Hunter McGuire, Nancrede, Weir, Stimson, and many others of equal note.

Under the heading of miscellaneous operations the author has given several of very diverse character.

First are quoted cases of osteomalacia, cured after weeks

or months of confinement in bed, by either oöphorectomy or Cæsarion section.

Passing to another subject, the question of graduated tenotomy of the eye muscles for the relief of severe nervous symptoms is carefully discussed. The author freely acknowledges the value of tenotomies, both complete and graduated, in the restoration of equilibrium in badly balanced ocular muscles, but he is none the less convinced that in numbers of instances of reported cures of chronic chorea, petit mal, and even delusional insanity the effect of the operation, *per se*, is in large measure, the potent cause of the supposed cure. This belief is founded not alone on theory, but upon the fact, that in certain cases of reflex nervous troubles a cessation of the symptoms has followed the tenotomy although this has not produced perfect equilibrium. Again the relapses which may take place after a perfectly successful series of tenotomies would indicate that the nervous phenomena attributed to the insufficiency, for the relief of which the operations were made, were not correctly so attributed, and that the temporary relief must be ascribed to some cause other than the restoration of an imperfect balance of the external ocular muscles.

In seeking for a reasonable explanation of the phenomena observed in the above cases, the author has formulated the conditions which are common to nearly all of them. These are:

1. Anæsthesia.
2. Psychical influence or so-called mental impression.
3. Relief of Tension.
4. Reflex action of the "reaction of traumatism."

These influences were operative in the majority of cases, although not one of them except the last applies to the whole list.

With the idea that it was conceivable that a disease of the nerve centres, not reached by ordinary drugs, might be affected by agents of such volatility and diffusibility as ether and chloroform, the author instituted a series of observations upon a number of epileptics in various stages of the disease. All other treatment was withdrawn, ether was given to the production of full anæsthesia at intervals of from forty-eight to seventy-two hours. The results were either entirely negative, or in consequence of the withdrawal of their bromides the patients grew worse.

Since, in the great majority of cases upon which Dr. White based his paper, there were either undoubted symptoms, such as are habitually associated with organic disease, or there was demonstrable and unmistakable evidence of such disease, it is necessary to believe, in considering the psychical influence of



operation, that powerful impressions acting upon the emotional or intellectual nature may effect the organic processes of secretion, nutrition, etc., and may arrest pathological changes and bring about reparative or recuperative action. Cases are cited in which such influences are clearly set forth.

The author holds that the normal equilibrium which we witness between the cerebro-spinal and the sympathetic systems, as respects their influence upon the blood vessel, is obviously more or less interfered with when the brain transmits a more than wonted impulse, allowing the unrestrained action or paralyzing influence of the sympathetic vaso-motor nerve. In this relation the author narrates some remarkable cases of hypnotism and quotes some striking examples of the effect of the central nervous system upon the body.

Belief is expressed that in many of the cases described there can be but little doubt that relief of tension is an important factor in amelioration or cure. If it is assumed that preternatural tension exist in the cranial cavity, this would be relieved to an extent by trephining, and there would be but few exceptions to the rule that in each case something was done which lessened the tension in the cavity or organ of the body. There are other cases, however, in which no such relief was obtained, and yet cure resulted from operation. A diminution of the tension would manifestly alter the blood supply to any important organ in the body, and with it, the nutritive process, local and general. Beyond this, nothing definite can be said except as it applies to cases of ascites in which, as in cases of hydrarthrosis, one tapping may prove prematurely curative because the original source of irritation and hypersecretion has already disappeared.

Under the head of "Reflex Action," the author includes the "reaction of traumatism," as well as the effects of revulsion and counter-irritation.

Verneuil has long since shown that very slight traumatism sometimes excites in the entire economy a general perturbation, and sometimes, by selection of the weak point, a sudden aggravation of lesions that are only slight or have slumbered. This same excitement, usually prejudicial, may occasionally be curative. In the case of spinal surgery above detailed, Dr. White believes that the local shock of the operation was promptly followed by a corresponding reaction, in which the vitality of the tissues was raised sufficiently high to determine a return to the normal state. In this relation the reciprocal influence of one portion of the body on another is briefly discussed.

In considering abdominal tumors attention is called to the possibility of the spontaneous disappearance of such tumor,

the relation of this disappearance to the operation being coincidental; cases are cited in point. As to the cure or amelioration of growths thought to be malignant by merely exploratory operation, a long search through the literature of the subject has met with but little success.

The cure of tuberculosis of the peritoneum as the result of exploratory incision is explained on the ground that the removal of ascitic fluid allows the peritoneal surfaces to fall together and to acquire adhesions. The tubercles are then shut in between the coils of intestine, the omentum and the abdominal wall. They are thus surrounded by tissues in a high degree of activity which can now throw around them the limiting zone of young cells and eventually fibrous tissue, which, if the tuberculous process is not too far advanced, may effectually resist it and may cause it to retrograde, the process being analagous to that which we see imperfectly going on around a cancerous growth.

As a result of a study of the subject the author believes the following conclusions are warranted:

1. There are large numbers of cases of different grades of severity and varying character which seem to be benefited by operation alone, some of them by almost any operation.

2. These cases include chiefly epilepsy, certain abdominal tumors, and peritoneal effusions and tubercle, though the improvement in the latter is, perhaps, to be explained on general principles.

3. Of the possible factors which, by reason of their constancy, must be considered, anæsthesia seems less likely to have been effective. The other three, viz., psychical influence, relief of tension, and reflex action, may enter in varying degrees into the therapeutics of these cases, and, taken together, serve to render the occurrence of occasional cures less mysterious.

4. The theory of accident or coincidence scarcely explains the facts satisfactorily.

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#### INJURY TO THE THORACIC DUCT, WITH AN UNIQUE AND INEVITABLE DEATH BY INANITION.

By Alvin Eyer, M. D., Cleveland, O.

December 17 last, Charles G. S. was admitted into Lakeside hospital with the following history: Railway brakeman, aged twenty-eight, with good general health up to previous day, when he met with an accident, the following report of which is as complete as could be obtained. By the slipping

of a "push pole" (a pole attached by one end to an engine and used in moving cars), he was so caught as to be squeezed against the foremost car and bodily rolled out from between the two. When picked up he was found several feet from the train and in an unconscious state.

Upon being brought some thirty miles, an examination brought to light little beyond severe localized pain in the right lower chest with some considerable injury to the right forearm, and a distinct band of discoloration some four inches in width, encircling nearly the entire abdomen. While no crepitus was found it was still thought best to firmly strap the right chest as a precautionary measure against possible fracture of one or more ribs. This, with attention to the injured arm and such anodyne treatment as was required, was all that was deemed necessary for the time being. In the course of twenty-four hours, however, there was a rise of temperature and upon auscultation evidences of pneumonia, corresponding to point of injury over right lung, were plain. He was at once placed upon additional treatment, and for the next sixteen days seemed to run a favorable, yet perhaps severe, course of traumatic pneumonia involving the entire lung.

Beyond somewhat more pain than one generally observes in such cases, however, nothing unusual presented itself, except on the second day, when there appeared a gaseous distention of the abdomen and also enough dyspnoea with a hyper-resonance of both lungs to suggest pneumothorax; but whether pneumothorax actually existed or whether this condition depended upon the abdominal distention was not definitely determined at once, and in twenty-four or thirty-six hours the whole chain of symptoms in so far as the thorax was concerned, passed away, leaving the patient about as before, with the exception of more or less constant abdominal tympany.

On the seventeenth day there came a great and most remarkable change over our case. Pain was complained of, and upon examination, some redness with soreness upon pressure was found directly above and somewhat behind the anterior superior spinous process of the right ilium. Upon deep pressure fluctuation could be obtained; and after the introduction of an exploring needle, an opening was carefully made quite down upon the external oblique muscle.

The moment the fistulous tract was struck there came a gush of most offensive gas followed by a flow of nasty-smelling discharge, not unlike fecal matter both in appearance and odor. So offensive was this discharge that the patient had to be removed from the general ward into an apartment by himself. An intestinal fistula was at once thought of, and in the next day



or two, with the opening still discharging a fluid very similar in appearance to what was given him to eat (expressed beef-juice, milk, and whiskey), and with repeated assurance of the orderlies that its odor was identical with what had passed per rectum, the diagnosis of such a fistula confirmed itself in our minds without further or special investigation.

After two or three more days the discharge lost its offensiveness to a very great degree; but otherwise remained much the same—opaque and milky—with marked increase of flow at any time the patient was asked to bear down as though at stool. At this time, too, rapid emaciation set in, and from these two facts—loss of odor and the unusually rapid emaciation—it was inferred that the intestinal lesion was high up and the food-stuffs given him came away as chyme. Under this belief it was deemed best to limit stomachic alimentation, as to quantity, and confine it entirely to predigested nitrogenous foods, while rectal feeding was pushed to its utmost limit. Notwithstanding, however, this forced feeding and the apparent well-doing of his pneumonia, the patient was still rapidly succumbing to starvation. So rapid was his inanition that it was estimated his body loss—from the date of fistulous formation (seventeenth day) to death (thirty-eighth day)—exceeded four pounds per diem, and that his entire loss much exceeded one-half his normal body weight.

During all this time we could see nothing to be done, more than sustain strength and life until such time as the patient's pneumonic condition would permit a restoration of the intestinal continuity, keep the tissues of the right side well open to favor drainage, and prevent sloughs. Starvation, however, went uninterruptedly on, and as already stated, death supervened on the thirty-eighth day after injury.

This, then, briefly stated, covers the history, clinical course, diagnosis and fatal ending of our case. To sum up its clinical significance we will take up: First, our diagnosis, not in its entirety, but only in so far as the fistula was concerned; second, the autopsy and its findings; third, a study of the case, upon the whole, with the view of establishing a differentiation between fistulæ communicating with the thoracic duct, and such other fistulous tracts as may prove undefined or doubtful as to origin.

(1.) In defence of our diagnosis of intestinal fistula I will only say: On the sixteenth day of observation of the case there were, with but three exceptions, absolutely no indications of disease or injury other than those referrible to the right lung—now in an advanced stage of pneumonia.

With the appearance, therefore, of the painful bulging, fol-

lowed by the rush of gas and fluid upon lancing, which plainly established the existence of some form of fistula, the exception—a band of discoloration, obstinate bowels, and slight tympany—were recalled; and, for the life of me, nothing could have been plainer or more easy to diagnose.

In fact, the whole case seemed too plain and simple to be mistaken. The gas and decidedly fecal smelling discharge in themselves moulded at once our belief, diagnosis, and mistake. That there was a fistula was plain; that it was fecal was too plain, and there we rested.

To give you the benefit that was given the house staff let me tell you, as was told them, how all this chain of concurrences happened:

“You see, this man was caught between the end of a pole and a box car; the little black and blue band about his waist plainly indicates to you what part of the body was caught. Now, the pole must have so squeezed the abdominal parieties up against the car, as to impinge a knuckle of gut within its embrace; and while this did no immediate or serious injury to the belly or its contents, there still must have been enough harm done to set up subsequently a low form of plastic inflammation whereby the gut and peritoneum became agglutinated and adhered one to the other.

“In due time, of course, death took place in that portion of the gut and the delicate serous membrane which was most centrally located in the adhesion, and then the tissues gave way and the fistula became established. Of course, it could not communicate with the abdominal cavity, because you see the opening through the gut and peritoneum was simultaneous; and as the healthy portions of the two are still adherent there is a sort of artificial anus formed, and through it, of course, the fecal matter must pass, then force its way on through the extra-peritoneal tissues in whatever direction it finds least resistance. Observe as you make pressure on this side a wave appears on the opposite side, not far underneath the skin, and beginning evidently in the linea alba. That is the fluid coursing its way through the newly made channel toward its outlet.

“As to what can be done in such cases, for the present we will only make a free opening, so as to give free vent and prevent the burrowing of fluids and subsequent sloughing. Later on, of course, when his pneumonia has subsided, laparotomy with, perhaps, enterectomy, will be performed, all of which will be a simple matter.

“Stimulate and feed him well, for as you see from what has been said concerning the character of the discharge, which

really seems to be nothing more than partially digested milk, whiskey, and beef juice, the lesion must be high up, and therefore the area for absorption is greatly cut off.

"The discharge which, you will remember, was so very offensive no longer smells badly, which also means that the foods leave the canal high up, and therefore have no chance for decomposition.

"This without doubt would be a nice case for Senn's hydrogen gas test, but, as the case is so plain and the poor fellow has already been badly hurt, we will pass that by. The pneumonia, of course, is a contra-indication for the use of anæsthetic, so all we have done, as you know, had to be done under the local spray and cocaine, neither of which is very effectual."

These, in substance, were the clinical points upon which was based our diagnosis two days after the fistulous formation. From then on the patient's pneumonia did well and seemed promising; and so was also our forced feeding borne, well by him, but he starved to death on the thirty-eighth day, and thus ended our first lesson.

#### AUTOPSY.

In making the autopsy it was at first determined to follow the tract from without in, but as it proved to run an unfavorable course for such a step, the attempt was abandoned and the abdomen gone into through the linea alba—the incision extending from the ensiform cartilage to the pubes. At first glance there could be seen many evidences of starvation's fearful ravages. All the viscera presented an unusual dryness, with the surface of the intestines and liver much darker in appearance than normal. The gall-bladder, was greatly distended and seemed on the point of bursting; while the omentum, always so rich in fat, was but a mere network of blood-vessels and connective tissue. These points being noted the point of "adhesion" was at once looked for, but no such condition could be found: and then a search for the fistula began. For this we looked high and low. Applying a double ligature just above the sigmoid flexure and dividing the gut between the two, we emptied the abdomen from below up, carefully noting every pathological change as we went.

Up to the diaphragm we failed to find even evidences of inflammation, new or old. In fact, the abdominal cavity seemed absolutely free from pathological conditions, and after going over the intestinal tract again and again, we thought it possible that the œsophagus might be the seat of lesion. So accordingly the liver and pancreas were removed and the diaph-



grom, beginning at the œsophageal opening, slit up to the ensiform cartilage.

In removing the liver from its lodgment it was observed that it was adherent to, and much softened about the aortic opening in the diaphragm, with evidences of recent inflammation, and several masses of a cheesy deposit, not unlike the residue of partially digested milk in appearance, embedded in its upper surface. The diaphragm up to the œsophageal opening also showed the same evidences of inflammation, and at this latter point the bands of muscle forming the opening were so adherent and matted to the gullet that, in separating and lifting the latter out through the cut made in the diaphragm, it was so torn as to prevent us from determining whether its destruction had been ante-mortem or made by us. From the character, however, of the blackened and broken-down tissues, not only of the liver but the diaphragm and œsophagus, and our failure to find any other lesion, we momentarily concluded we had reached the seat of trouble.

The sternum and cartilages were next removed and after carefully examining the diseased right lung, which was found in various stages of hepatization, the same was lifted out of the thorax, and the upper surface of the diaphragm about its openings further examined. Its condition was similar to that found below, except, perhaps, that the inflammatory process had not been so extensive. The gullet above this point was also further examined but found to be perfectly healthy. Upon complete removal of the lung from the chest there was discovered a bulging into the cavity, from the back and uppermost point of its apex, which upon more careful investigation was found to be a post-pleural collection of fluid. Upon tapping its sac this fluid seemed to be identical with that which had been making its escape per fistulam during life, and further examination proved this finding to be correct. The pent-up fluid was our supposed chyme, and had burrowed its way between the pleura costalis and chest-wall by gravity while the patient was flat upon his back. A careful dissection also proved the incorrectness of our just-formed belief that the lesion could have been in the œsophagus at the point of opening in the diaphragm, for in no way could that tear and the newly found cavity be made to connect. This discovery, then, put us entirely at sea, and it was not until the bulging pleura was again referred to and its contents found to consist of a rich creamy clot, overrun by a brownish liquid, that a chyle-clot and lymph were thought of.

Specimens were at once examined by heat and the micros-

cope. The former clearly proved the fluid to be pure lymph, while the microscope showed us a collection of the most beautiful specimens of chyle-corpuscles ever looked upon. Thereupon the autopsy was brought to a speedy end by going directly into the posterior mediastinum, and but little deeper than we had gone for the gullet, where the hard-looked-for hole was found—not in the alimentary canal, however, but in the thoracic duct. It was through this hole, then, that all our endeavors for the poor fellow's life had slipped. The fistula was found within the very opening formed by the diaphragm for the tube's reception, and the diaphragmatic crura, fasciculi, and interdigitations surrounding it likely had much to do with its formation and probably led to the division of the stream of chyle, directing the one into the thorax and the other through the muscles of the back and abdomen to its ultimate point of outlet.

#### POINTS OF DIFFERENTIATION

*As Presented in this Case, Bearing Directly Upon the Non-existence of Intestinal Fistula, and Somewhat Plainly Indicating Division of the Thoracic Duct.*

Under this head comes, first in order, Senn's hydrogen gas test. Had this test been applied, without doubt its results would have led to such further investigation as would have ultimately led to a correct diagnosis. Second, heat test and microscopic examination of fluids discharged. Had the former test been resorted to, these would surely have followed and a correct diagnosis might possibly have been arrived at. Third, shortness of inanition period. This, it would appear, should prove, in an otherwise healthy subject, a strong and emphatic diagnostic point indicative of thoracic duct destruction.

The adult subject, it is well known, succumbs to starvation in twenty to twenty-four days; but the phenomenon generally takes place under the withdrawal of all nourishment. Here, while the subject was suffering from pneumonia, and was supposed to have an opening near the stomach through which his food escaped, death still came entirely too soon; for under the forced rectal alimentation, life should have been maintained for many weeks longer, had the fistula been elsewhere than in the thoracic duct.

#### COMMENTS WORTHY OF RECORD.

In endeavoring to arrive at the probable cause and time of lesion, which it seems to me would be of interest to know, two questions put themselves: Was it the destructive outcome

of existing inflammation and formed on, or about the seventeenth day? or: Was it purely traumatic and formed on the day of original injury? The inflammation about the aortic opening in the diaphragm and adjoining structures, as found in the post-mortem examination, with the intervening sixteen days before the fluid came to the surface, combined with the terrifically rapid emaciation after the seventeenth day, would all speak strongly in favor of the first proposition.

In my judgment, as formed from a careful noting of the entire case, however, it would be under the latter proposition that the actual cause and time should be placed. In support of this, I would argue that the division was sustained in the accident, but happened to be so located within the grasp of the tendinous arch, thrown from one crus of the diaphragm to the other, that immediate continuous escape of lymph was checked, and the chyle-clot (found upon the removal of the liver), allowed to form in the tissues about the lesion, and so pack and arrange itself there as temporarily to dam up the break. I believe this condition to have existed up to about the sixteenth day, when the inflamed tissues gave way and the burrowing of chyle began.

The main point in support of this theory is to be found in the peculiar tympany appearing on the second day after the injury. The distention, which was not only peculiar in its mode of coming, but remarkably so in its stay, could not, at the time, be accounted for. The symptom proved unusually distressing, because of the existing pneumonia, and in our efforts to dispose of it full doses of salts were given, but to no avail. While the bowel discharges were copious and watery, the tympany still remained. This, it now seems, must have depended upon the gas being in the peritoneal cavity, and not in the intestines; and from its existence and its time of existence I infer it to have been a phenomenon coincident to the injury to the duct and also, therefore, a datum fixing the time of said injury.

As to the cause of such an injury one could hardly conceive its possibility. Whether compression of the lower abdomen could so forcibly crowd its viscera against the diaphragm and upon the, perhaps, well-filled duct, as to injure it; or whether the squeeze to the chest could have caused such forced respiratory efforts as to produce it; or whether an over-excited diaphragm could cause it by its muscular contractions, are only possibilities to be conjectured, but not shown. How this tube, lying as it does between the aorta and vena cava, could be singled out and divided by causes either indirect and



inflammatory, or direct and traumatic, without also tapping one or the other of its fellow companions, seems to us as incomprehensible, in the study of nature's method of applying her causes in obtaining her effects, as does it seem irrational that she should assign to this poor mortal a death so sure, yet indirect and terrible, as starvation, when she might as well have decreed the tapping of either one of said vessels and let forth his simple life in a single moment, without bodily pain or mental suffering.

It will be observed that in the autopsy no evidences of inflammation were to be found other than those in the lung, diaphragm, and the structures immediately adjacent to its aortic opening. These, of course, must be regarded as entirely traumatic. The post-pleural cavity, containing at least two pounds of chyle, with the channel leading to it from the point of rupture in the duct, also the upper two thirds of the tract through the extra-peritoneal tissues, were as free from inflammation as though nature had formed and lined them. This latter condition, which positively demonstrates the non-irritability and homogeneousness of chyle to the textural structures of the human body, suggests two points of interest:

1. Could the chemico-physiologist ever be enabled to elaborate out of food stuffs a product identical with that made in the human digestive laboratory, then it would appear the surgeon's skill and ingenuity might lead to some form of venous feeding whereby life might be indefinitely maintained.

2. Bearing upon the much-discussed question of asepsis versus antisepsis the case in point furnishes much practical information favorable to the former theory. Here existed a collection of chyle, pent up between delicate and sensitive tissues for a period of at least sixteen days, without the slightest evidence of inflammatory irritation. Had it been bile, gastric or pancreatic fluid, or even blood, surely no such inaction could have been expected. Upon what, then, could this difference depend other than the possession by the four latter fluids of materials septic to the body tissues, on the one hand, and the asepsis of the sterilized chyle, by virtue of its digestion, on the other? The mechanical irritation, by contact, of this fluid must certainly be as great as that of sterilized water by boiling at blood heat; and therefore it would appear that the aseptic condition of the surgeon and his materials in use should become in the end practical, and by all means preferable to the dangerously potent antiseptic remedies used as germicides.

—*Medical Record.*

## MEDICINE.

## DISINFECTION OF TUBERCULOUS SPUTUM.

In the *Centralblatt für Bakteriologie*, Nos. 1 and 2, 1891, Dr. Martin Kirchner points out that the general consensus of opinion has come to regard the sputum of tuberculous patients as the ordinary means by which tuberculous disease spreads from one individual to another. In many of the large military establishments in Germany it has been shown that tuberculous disease has been very widespread amongst the nurses and attendants upon the sick, and stringent rules are already in force in many such places to prevent the indiscriminate disposal of sputum. Tubercle bacilli are more resistant than some other microorganisms to the action of some antiseptic fluids, but are very easily destroyed by others. Four per cent. carbolic acid with the addition of 2 per cent. of hydrochloric acid; 2 per cent. and 5 per cent. of sulpho-carbolic acid, or 10 per cent. of creolin, will suffice to render tubercle bacilli innocuous in a very short time. Caustic soda and potash on the other hand, and 5 per cent. of permanganate of potash have no effect, nor is a solution of 1 in 1000 of corrosive sublimate sufficient, owing to the highly albuminous character of the sputum in which the bacilli are contained. It has now been proved that tuberculous sputum may retain its infective properties for ten months even after decomposition or drying up. It must, therefore, be equally active, as it lies in the various receptacles which have been devised for its reception. The methods by which these vessels are cleaned becomes a matter of considerable importance. Boiling water is used in some places, but it is open to the chance of the water becoming cool before it can be used, and does not do away with the necessity for the wiping of the adherent sputum from the sides of the vessel by the hands of the attendant. A temperature of 70 deg. C. has been shown to be insufficient to render tuberculous sputum innocuous, and the author of the paper believes that absolute disinfection is only to be obtained by means of steam. This plan was advocated by Grancher and de Gennes in 1888, but the apparatus devised for the purpose was cumbrous and costly. Now that there is a general disposition to treat tuberculous cases on much the same lines as leprosy cases, by collecting them together, it should be an absolute law that all the sputum proceeding from such cases should be rendered harmless before it is disposed of in the common drains. With this object, Dr. Kirchner has caused a

form of disinfecting kettle to be constructed, consisting of a round metal box about 10 inches high and 16 inches in diameter, its floor forming a shallow tank to hold the water to be vaporized, the whole being covered with a lid perforated at one point for the passage of a thermometer. In this box are placed two or more trays perforated to permit of the free circulation of steam, and so arranged as to carry five spitting cups of the special pattern which he uses. These cups are placed for half an hour within this apparatus, heat being maintained so that the temperature of the steam never falls below 100 deg. C. A strong protest is made against the use of the ordinary spittoon, whether filled with sawdust or some anti-septic fluid. The spittoon is of necessity too far removed from the patient's mouth to ensure that all the expectorated matters are collected by it. The state of the floor round and about any spittoon in a public place is appealed to as sufficient evidence of the truth of this statement. Small cups made of glass, with wide lips, and easily cleaned, should be used in preference to the spittoon, but must be placed within reach of the patient's hand, and be clearly labelled. These cups must be placed in the disinfecting box for half an hour before they are emptied, and their contents may then with safety be treated by simple washing.—*British Medical Journal*.

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#### HISTOLOGICAL AND BACTERIOLOGICAL RESEARCH ON LEPROSY.

GIANTURCO (*Giornale della Associazione Napolitana di Medici e Naturalisti*, 1890, Fasc. 4, p. 403) obtained fragments of cutaneous lepromas from the body of a man who had been affected with mixed leprosy. Histological examination showed these lepromas to contain a great number of bacilli. According to Gianturco, the localization of the bacilli lepræ and their relations to the cellular elements, vary during the period of the morbid process. In the most recent nodules the bacilli are almost all present in the cellular elements, and the rounded zooglœa mass which is formed later is not then produced. At a more advanced stage the bacilli multiply, forming a globular mass, rarefying the cellular protoplasm in which vacuoles form. The nucleus is in turn invaded, is badly colored, atrophies, and then, probably in consequence of the destruction of the cell, the masses of bacilli become free in the lymphatic channels. Gianturco has confirmed the existence of the same lesions in the lepromas of the larynx. In the liver he found an increase of the interstitial tissue under



the form of embryonic cells, and, in places, true nodules continuous at their periphery with the interacinous connective tissue. The hepatic cells are in a general way intact, especially those of the centre of the lobule, yet those of the periphery of the lobule may present adipose infiltration and granulations of biliary pigment; their nuclei, swollen at the commencement, afterwards present vacuoles. The lymphatic glands contained, both in the medullary and cortical substance, leprous nodules showing a giant cell at their centre. With the juice of a cutaneous (not ulcerated) leprous nodule, Gianturco made inoculations on blood serum and on glycerine agar, the tubes being kept at a temperature of 37 deg. C. Cultures developed in all the tubes, one of which presented at the end of seven days an isolated colony of the size of a hemp-seed, somewhat projecting from the surface of the agar, of a grayish color, and perfectly similar to the colonies of bacilli lepræ described by Bordone-Uffreduzzi. The bacilli of this colony were of variable length, with clear spaces, and some coloring strongly, and possessing a terminal swelling. Inoculations made with these bacilli on glycerine agar gave rise, at the end of two days, to colonies which develop somewhat rapidly on the surface of the agar. On glycerine serum they develop rather quickly, but on the agar alone the development was very slow, and the colonies much smaller than on glycerine agar. They did not develop on other media. The colonies were rounded, with finely serrated borders, scarcely projecting from the surface of glycerine agar, a little more prominent on glycerine serum. They were of a grayish color, appearing a little yellow on the serum; and resembling small leaves of trefoil when developed along the line of inoculation. They developed well at 37 deg., but the growth was arrested at 20 deg. to 25 deg., the faculty of development being preserved for a long time. The above bacteriological researches support the statements made by Bordone-Uffreduzzi, but it must not be forgotten that other observers, and especially Campana, who has devoted much time to the matter, have never succeeded in cultivating the bacilli lepræ.—*British Medical Journal*.

[Since the above was published, the Hyderabad Leprosy Commission has succeeded in cultivating the bacillus lepra, and has successfully inoculated rabbits with the cultures.—ED.]

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#### THE INHALATIONS OF OSMIC ACID IN PULMONARY TUBERCULOSIS.

From *El Siglo Medico* we learn that Dr. Don Francisco Valenzuela read a very valuable paper before the Medico-

Chirurgical Academy of Madrid, at the meeting of June 1, 1891, in which he speaks of the excellent results obtained by the inhalations of osmic acid in sixteen of his hospital patients suffering from incipient pulmonary tuberculosis. The histories of the following three cases were especially reported by the doctor, the patients having been presented at the meeting. The other patients have left the hospital in a fair way of recovery.

CASE I.—J. M. entered the hospital on February 3, 1891, presenting all the broncho-pneumonic symptoms of incipient tuberculosis, without signs of consumption; there were respiratory mucous rales at the apex of both lungs, accompanied by rough inspiration. He was immediately subjected to daily inhalations of osmic acid, which he is still using. The broncho-pneumonic symptoms have disappeared; the normal respiratory murmur has returned, and no trace of the disease is left.

CASE II.—In this case the tuberculous process was more advanced. The patient, F. R., entered the hospital on December 11, 1890. He had light and repeated hæmoptysis, remittent fever, profuse night sweats and abundant expectoration. Dull percussion in the right side of the chest, extending through the greatest portion of the right lung; complete absence of the respiratory murmur, with sibilant and moist rales. Treatment was commenced the same day, and the patient is still under it.

Actually all broncho-pneumonic symptoms have disappeared. The physical signs give evidence of a remarkable repair of the affected tissues; no more dullness or percussion; the air enters the lung freely; the respiratory murmur is normal, though rather rough, on account of previous disease, which left cicatrized condensations of certain portions of the lung; the heart is a little displaced upwards, probably from the same cause. The patient eats, and nourishes well; he does not cough nor spit.

CASE III.—C. J. entered hospital on March 1, 1891. About the same symptoms as those of case No. 2, with the exceptions that the left lung was not the affected one. With the inhalation of osmic acid the doctor promptly obtained the return of the permeability of the lung, and the disappearance of the local and general symptoms of consumption. The only abnormality remaining is some infiltration and condensation of the same lung, which the doctor believes will not be progressive, and hopes for a quick recovery.

The three patients were examined by the members of the academy, and their remarkable improvement was acknowledged. It is to be regretted that the paper does not make any

mention about microscopical or bacteriological examination of the sputa. It would have thrown more light on the diagnosis. The results, however, so far obtained by Dr. Valenzuela are encouraging, and it is worth while that the attention of the profession be called to the treatment. If we succeed by osmic acid inhalations in arresting the progress of pulmonary tuberculosis in its incipency, it will be a great step in the right direction—indeed, the most important one.

DELL'ORTO.

### MUSCULAR RHEUMATISM AND ITS TREATMENT.

Clinical Lecture by PROF. POTAIN.

At the present moment we have in the clinic a man, age 22, who complains of generalized pains in both of his arms, and affecting slightly his legs; at the same time he has a little fever. As he is kept motionless in his bed by his pains, one might at first think that he is suffering from a general articular rheumatism; but, upon attempting to locate accurately the seat of his sufferings, it is seen that the joints are neither painful nor swollen, and that the pains are myalgias, occupying the length of the limbs outside of the articular regions.

The pains, then, are seated in the muscles. In the neck, where they are well marked, the patient complains chiefly of the sterno-cleidomastoid; in the forearm, the flexors are chiefly involved; in the legs, the pain, while affecting the whole thigh, is especially marked at the hip over the site of the tensor vaginæ femoris. The pain is not increased by pressure upon the affected muscles, while contraction of the muscles aggravates it. That is why the patient feels a severe pain in the forearm when he tries to close his fist. It is the same in the lower extremities; the pains are absent during repose, and are barely felt upon adduction and abduction. In the neck movements of the head naturally provoke pain.

In our case all the characteristics of muscular rheumatism are found: deep, dragging pains, with notable dartings situated along the muscular masses, not provoked by passive motion, barely increased upon pressure, and aggravated by active movements.

We have, therefore, a case of muscular rheumatism, which is, however, of an unusual form. This disease is almost always limited, circumscribed, and mono-muscular, or, at any rate, affects but a small group of muscles, or muscular region. It only rarely happens that it is diffuse and shifting, like the acute articular form.

Some doubts have been expressed concerning the rheu-



matic nature of the disease. In fact, we do not possess any special characteristic that would enable us to affirm absolutely the rheumatic nature of any affection. It is very probable that we have to deal with an infectious agent; but, up to the present time, this infectious agent has not been cultivated and the disease has not been reproduced by inoculation.

In acute or subacute articular rheumatism, the muscular manifestations occupy chiefly the fibrous or tendinous ends of the muscles; but in certain cases the body of the muscle is also affected.

We should be careful to distinguish muscular rheumatism from certain muscular troubles that occur in the course of acute articular rheumatism, and do not depend upon the rheumatiferous agent. The muscles surrounding a joint undergo atrophy when the articular lesion is prolonged; for instance, the quadriceps femoris often atrophies after rheumatism of the knee. In this case, as the joint is surrounded by the muscle, it might be said that latter suffered directly from the articular fluxion, and the same supposition might be advanced in regard to the deltoid; but this hypothesis can not explain in the hand the atrophy of the lumbrical muscles which gives to the fingers of rheumatic patients their peculiar aspect. Neither can it explain the atrophy of the muscles of the forearm in inflammation of the wrist. Finally, since atrophy also appears in articular lesions generally, it certainly is not to be regarded as peculiar to rheumatism.

Muscular rheumatism becomes associated very easily with articular rheumatism, when it appears in the course of the latter. It is thus that torticollis, with its peculiar pains, may be met with, independently of any affection of the vertebral column. In the same subject we may see muscular rheumatism and articular rheumatism occur independently of each other, under analogous causes.

Two years ago our patient had a characteristic attack of articular rheumatism; and, moreover, he regards his present malady as identical with the previous one.

As I have already remarked, muscular rheumatism so generalized as we see it in this case, is exceptional; the disease is usually limited. You all know epicranial rheumatism, rheumatism of the neck (much more frequent), of the loins (*lumbago*), and that of the shoulder (affecting chiefly the deltoid); the muscles of lower extremities are much more rarely affected; finally, rheumatism of the abdominal muscles is not absolutely rare.

What takes place in the affected muscles? Pathological anatomy throws no light on the subject. There is no atrophy,

except in the chronic form, and nobody ever dies with the disease, unless carried off by some concomitant affection. My colleague, Prof. Hayem, has found only a slight fluxion, but not enough to increase the volumes of the muscles. In myositis, on the contrary, there is swelling of the muscular fibres. In chronic myositis there is no sclerosis of the muscles; but these lesions are different from those of rheumatism.

Muscular rheumatism is to be recognized only by its special pain; and the diagnosis is sometimes a delicate matter. When there is an articular lesion or a lesion of a serous membrane, the clinical characters are generally clear enough to enable one to affirm or deny the rheumatic nature of the case under consideration. When the muscles or the mucous membranes are attacked by rheumatism, only functional disturbances exist with the pain, which latter is well marked in the second case and but slightly in the first. It is important to distinguish muscular rheumatism from other affections attended with diffuse pain in the limbs, or from certain intoxications accompanied by myalgias, lead poisoning, for instance. However, all the infectious diseases, offer special characters, and I will merely say a word about the form of myalgia which accompanies herpetic fever, ephemeral fever, synochus, characterized by small blisters on the lips. The fever is quite often accompanied by pains in the limbs; but those pains are more diffused, do not predominate in muscles or groups of muscles; finally the sufferings are almost continuous, which is not the case in muscular rheumatism.

The treatment of the acute form of muscular rheumatism does not differ much from that of acute articular rheumatism; there is a similarity in the nature of the two diseases, and this authorizes to employ similar remedies. Salicylate of soda is indicated, and it gives good results, though not as strikingly as in acute articular rheumatism. The remedy acts better the more acute the disease is; in chronic articular rheumatism it has no effect. The same may be said of subacute and chronic muscular rheumatism. However, there are certain cases of the chronic form, not fibrous, in which the salicylate has been successful. Antipyrine is also useful in the chronic forms.

Wet cupping, so often resorted to, has a rapid and complete effect, more by cutaneous derivation than by the small loss of blood it occasions. The same effect may be obtained by making multiple acupuncture, and then rubbing some irritating oil on the skin. Faradisation, which produces a redness of the skin also gives good results. We can cause the pain to disappear by injecting beneath the skin a feebly irritant liquid, for instance, pure water. It causes the muscular pain

to vanish at the cost of a sharp but momentary pain in the skin; if this be not felt, no therapeutic effect is produced. The first effects are produced after the injection of any liquid that causes pain, such as alcohol or ether. Chloride of methyl sprayed over the affected parts may do some good. All these measures are efficacious in cases in which the rheumatism is about to recede, but are of no avail in the chronic form. Then we should resort to heat, steam baths, massage, hot sulphurous baths, etc.—*L'Union Médicale*. A. MCS.

#### THE DIAGNOSTIC VALUE OF THE DIPHTHERITIC BACILLUS.

Dr. Simon Flexner, of Louisville, in an article on the Diagnostic Value of the Bacillus of Diphtheria, says:

In an article contributed by Loeffler, to the *Berliner Klin. Wochenschrift*, in 1890. (*Welche Maasregeln erscheinen gegen die Verbreitung der Diphtherie geboten?*), he considers the measures which should be carried out in securing prophylaxis in diphtheria, and his conclusions are:

1. The cause of diphtheria is the bacillus diphtheriæ, and it is found in the exudation of the diseased mucous membrane.

2. The bacilli are thrown off with the membrane. They can be deposited on everything in the neighborhood of the diseased.

3. The bacilli are capable of causing infection in others as long as the slightest trace of membrane is still present, as well as for a number of days after the disappearance of the membrane.

4. Those sick of diphtheria are to be carefully isolated and kept in isolation as long as bacilli are found in the secretions. Children who have had the disease should be kept from school not less than four weeks.

5. The diphtheritic bacilli retain their vitality in pieces of membrane for four or five months. It is, therefore, necessary to treat everything that may have been infected by the patient, such as wash, bed-clothes, glasses, dishes, cloths, etc., with boiling water or live steam, while the room in which the sick has lain must be carefully disinfected. The floors are to be washed with a warm solution of bichloride of mercury, 1 to 1000, and the walls and furniture are to be rubbed down with bread.

6. Investigations concerning the vitality of the bacilli in damp surroundings are not yet completed. They are probably more resistant under these conditions. Damp and dark homes seem to be favorable for the preservation of the vitality



of the diphtheritic virus, hence, such homes have to be emptied and opened for the purpose of drying them and for the entrance of light and air. In change of places of living it is especially important that a careful disinfection of the infected home and its contents be made.

7. The bacilli increase outside of the body at 64 deg. Fahrenheit. Milk is an excellent medium for their multiplication. Great care is necessary not to use milk that may come from dairies in which diphtheria is prevailing.

8. Diphtheria of many animals—pigeons, hens, calves, and pigs, is not produced by the same germ that causes the human disease. These animals are not to be feared as sources of human diphtheria. Nothing positive can be said at this time of the diphtheria of cats.

9. Lesions of the mucous membrane favor the invasion of the virus. Susceptible individuals may become affected without such previous lesion.

10. In times when diphtheria prevails, it is of importance to have the mouths, noses, and throats of children clean. For this purpose weak sublimate (1 to 10,000) or an aromatic wash is to be recommended.

The last communication by Loeffler on this matter, has for its subject the therapeutics of the disease (*Zur Therapie der Diphtherie, Deutsche Med. Wochenschrift*, 1891, No. 10). In the experimental examination of various drugs and agents which have been used or promised good results in the treatment of the disease, he has endeavored from the beginning of his inquiry so to conduct his work that the practical problem should be approximated as closely as possible, and a practically useful result be obtained.

In combating the diphtheritic bacilli, there are two points to be overcome:

1. To prevent the settlement of the bacilli in the intact mucous membrane of well persons, and on the adjacent unaffected mucous membrane of those suffering from the disease. This settlement of the bacilli is to be prevented either by applying to the healthy mucous membrane such substances as hinder the development of the bacilli, or, what is better, perhaps, by destroying in the shortest time possible, the somewhat non-resistant bacilli which have settled there. It is evident that the means must be such as will not injure the mucous membrane itself or affect the body by its poisonous properties.

2. The bacilli in the pseudo-membrane must be killed in order to prevent the spread of the disease in the person already affected, and to remove the danger of transmission to others.

For the proper investigation of these features it was necessary to use a culture medium in which the bacilli grow as rapidly as in the throats of children, one which is easily and perfectly capable of observation and that admits of being maintained at the proper temperature. By the use of the blood serum-bouillon medium, Loeffler believed he had secured these requirements.

His method was to inoculate such culture-tubes with a dilution in water of the bacilli by drawing a platinum needle carrying a minute quantity of the suspension of the bacilli over the surface of the solidified serum. Placed in the breeding-oven they showed a uniform coating of colonies after twenty-four hours. Into these tubes of fresh colonies, representing the bacilli in contact with the healthy mucous membrane, the reagent was brought and the contact allowed varied from momentary (the fluid being poured off immediately) to ten, twenty, or thirty seconds, corresponding to the length of time one can gargle with comfort.

As soon as the reagent was removed a fresh transplantation of the colonies treated was made, and the results watched and noted.

If the colonies of the original tubes inoculated with the suspension of the bacilli are permitted to grow for several days, a layer of colonies about  $\frac{1}{2}$  mm. thick is obtained. This represents the growth in the superficial portions of the mucous membrane. Tubes prepared in this way were tested also, and a large number of reagents were employed. I will give one case as an example of Loeffler's method, and then his conclusions:

A solution of corrosive sublimate of the strength of 1 to 10,000 by momentary contact would destroy the fresh culture (twenty-four hours old); with a dilution 1 to 20,000 only a few colonies remained; but after twenty-four hours longer the growth remaining after treatment with 1 to 20,000 developed into strong colonies. Essentially weaker was the effect of a 1 to 10,000 solution on the older cultures. A solution of 1 to 2000 with a contact of twenty seconds had not penetrated the deeper layers; but a similar contact with 1 to 1000 solution killed nearly all the deeper layers. Stronger solutions killed all colonies. Cyanide of mercury proved effective, and has less of the metallic taste. Carbolic acid was satisfactory also.

Hence, in conclusion, Loeffler recommends that as a prophylactic a gargle be used every three or four hours, consisting of a solution of bichloride of mercury of 1 to 15,000 to 1 to 10,000, or cyanide of mercury of 1 to 10,000 to 1 to 8000. Chloroform-water is useful for the same purpose, and not

unpleasant; and a 1 to 500 solution of thymol in 20 per cent. of alcohol.

In handling those sick of the disease he suggests using one of the weak gargles every one or two hours, and a 1 to 1000 solution of sublimate; a 3 per cent. solution of carbolic acid in 30 per cent. alcohol, or a mixture of alcohol and turpentine, equal parts, containing 2 per cent. of carbolic acid, every three or four hours. Finally, penciling the throat with a 5 per cent. solution of carbolic acid is added.

These solutions has been proven experimentally, not only to prevent the settlement and development of the bacilli on the adjacent healthy mucous membrane, but to destroy the bacilli in the deeper layers of the culture  $\frac{1}{2}$  mm. thick. And in two clinics in Berlin, one of Dr. Mosler and the other of Dr. Strubing, in which the carbolic acid and sublimate solutions were used respectively, the most excellent results were obtained; and, whereas by ordinary methods of treatment virulent bacilli were found in the throat after three weeks, when the above methods were followed they could not be found after a few days.

Hence, the disease is not only shortened by this treatment but the affected individual ceases to be a menace to others much earlier than he would otherwise be.

In conclusion, I wish to emphasize the fact that in the last decade, by the employment of modern methods of research, more light has been thrown upon this disease than in more than a half century before since its description, and that there is probably no other disease, hardly excepting tuberculosis, that has been rendered so clear in its etiology and pathology, so amenable to prophylaxis, and so promising to treatment.—*American Practitioner and News.*

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## LARYNGOLOGY, RHINOLOGY AND OTOTOLOGY.

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### FOREIGN BODIES IN THE AIR PASSAGES.

Dr. Jno. E. Pendleton, of Hartford, Ky., reports fourteen cases of "Foreign Bodies in the Air Passages," in the third volume of the *Southern Surgical and Gynecological Transactions*:

CASE I.—Child 2 years old, suffering with a large inflam-



matory swelling of the parotid region, side of neck and head; had an attack of croup three weeks before that; came near suffocating it. Upon examining the parotid swelling, fluctuation was detected; swelling was punctured with a scalpel when there came in view pus and a hard-pointed substance that proved to be a feather, which, no doubt, had caused the croupal symptoms three weeks before.

CASE II.—Mr. B., while hurriedly eating was seized with severe laryngeal spasms.

Recurring attacks came on at intervals of an hour or so, but finally subsided. Upon examination with head and throat mirrors a bit of chicken bone was noticed with its head resting on the left aryteno-epiglottidean fold, while the point was buried in the tissue at the posterior side of the larynx. It was removed with laryngeal forceps. Decided force was required in its removal which was followed by bloody expectoration. Recovery was immediate and without note.

CASE III.—Fell dead upon the dining table. At the autopsy a piece of gristle was found wedged in the larynx which was doubtless the true cause of death.

#### FOREIGN BODIES IN TRACHEA.

CASE IV.—E. M., female child, aged 18 months, was found by its mother to be choking. The suffocative paroxysms were frequent and threatened life. After a hasty physical examination the case was determined to be one of foreign body in the trachea. Delay being out of the question, chloroform was given, the trachea was opened and a seed of watermelon extracted. The relief was instantaneous and the wound healed by first intention.

CASE V.—Hettie H., aged 7 years, while having a shawl pin in her mouth, was taken with a fit of sneezing, in which the pin passed into the trachea. The immediate symptoms were very distressing, but were finally followed by quiet. The symptoms becoming suddenly more threatening and the patient more exhausted, tracheotomy was performed under chloroform. The pin was searched for with a silver probe and found just below the thyroid cartilage; with forceps it was pushed through the trachea and removed through an incision made one inch above the tracheotomy wound. The wound in the neck and trachea healed after several weeks, leaving an ugly cicatrix. The young lady is now a far-famed Kentucky beauty.

CASE VI.—Mary T., aged 6 years, while running at play, tripped and fell, and inspired one of several grains of corn which she was holding in her mouth at the time. The symp-

toms were at once urgent; the attending physician insisted on opening the trachea but parents obstinately refused. For six weeks patient continued to suffer dangerous paroxysms of suffocative cough. Bronchial inflammation, with pneumonia in the right lung, set in, followed by purulent expectoration, fever, and night sweats, leading to pyæmia and extreme exhaustion. Child could not tolerate pressure on chest from any direction, and for several weeks had to be supported in a sitting posture by holding her arms. Knowing that tracheotomy was the only chance, it was urged and performed. From within the trachea, through the tracheal wound, there poured out about two ounces of blood, two or three ounces of fetid pus, and following it a grain of corn. Recovery was retarded by the abscess in the lung, which, however, finally filled up, and she is now in perfect health.

CASE VII.—Wm. C., aged 5 years, falling from a fence, inhaled a little bean which he had in his mouth. Blood came from the nose and mouth, the face was livid, the eyes protruding; these violent efforts at respiration left him unconscious after each paroxysm, which continued to occur until strength was exhausted. Holding him in the erect position would shorten the fit and lessen its severity. Dr. P. saw him twenty-four hours after the accident. He could not bear the least pressure on the chest. Tracheotomy was performed under chloroform, and the bean after being drawn down the trachea by a full inspiration, was expelled by a forcible expiration. The wound was completely healed in a few days.

CASE VIII.—M. G., female, aged 11 months, while eating potatoes and fish prepared by her mother, became suddenly choked. A physician was called who failed to give relief. Dr. P. saw the child the next evening and thought it was moribund; however, four of the tracheal rings were incised, which immediately relieved the distressed breathing, but no foreign body could be seen in the trachea. Forceps could not be used in the trachea, because of its small size, therefore a delicate bent probe was passed upward and made to grasp the foreign substance in its curve. The foreign body was broken in two pieces by the considerable traction required to dislodge it; one piece was removed through the tracheotomy wound, and the smaller piece caught up through the mouth. It proved to be a fish bone three-fourths of an inch long, one-third of an inch wide and one-fourth of inch in thickness; rough, irregular and semi-circular in shape. Tracheotomy wound healed kindly; child is now well.

CASE IX.—J. P., young college student, had a chronic pharyngitis for which he gargled with kerosene oil, through

the advice of a charlatan. Almost a tablespoonful of that irritant was inhaled into the trachea at the first experiment.

Alarming and distressing suffocative symptoms immediately ensued; the violent laryngeal spasm would only subside when life was almost extinct, to be renewed again and again. Bloody froth was blown from the mouth and nose, the eyes protruded; these efforts were continued until patient was completely exhausted.

Dangerous inflammation of the mucous lining of the air tracts and cells, and œdema of the glottis were lighted up. The œdema was punctured. The broncho-pneumonitis continued for several days; the temperature reaching as high as 104.20 deg. At the expiration of two weeks, he could speak above a whisper only. He slowly recovered.

CASE X.—W. McG., aged 2 years, was seen by Dr. P. three days after a grain of corn had entered his trachea. Physical signs, paroxysmal choking cough, and history made the diagnosis certain. Tracheotomy was urged by Dr. P., but not allowed by parents. He returned home and died on the sixth day in a fit of protracted asphyxia.

CASE XI.—John P., aged 18 years, inhaled a cockle-bur into his trachea, while attempting to remove it from his glove with his teeth; suffering described as terrible agony. Dr. P. saw him two hours after the accident when he was completely exhausted and partially narcotized by a dose of morphine given by the previous medical attendant. Countenance was anxious, pulse rapid, respiration asthmatic and labored. Aphonia was complete and due probably to the spires of the bur which was movable and changed its location with respiration. Tracheotomy was proposed, but most emphatically refused by the mother, notwithstanding the patient's willingness to submit to the operation after three months' of dreadful suffering that led to hectic fever, night sweats, purulent expectorations and extreme emaciation; he coughed up the bur and recovered.

CASE XII.—James G., aged 18 years, came to Dr. P. with a cockle-bur in his trachea. He refused tracheotomy, went home and had a similar experience to that of the preceding case, except that the bur was not expelled until five and a half months had elapsed from the time it was inhaled.

CASE XIII.—Symptoms mistaken for those of an acute asthmatic bronchitis. Jno. T., aged three years, while running, knocked his head against a chair and fell. He was picked up and found to be livid and struggling for breath. Acute distress continued until Dr. C. arrived. The doctor did not suspect the presence of a foreign body in the trachea,



but attributed the symptoms to shock. After examining the chest he gave an emetic, followed by potions containing opium. For three weeks the suffocative paroxysms of coughing continued, and the signs of broncho-pneumonitis in the right lung persisted. The distress finally became less urgent. Several physicians agreed to its being broncho-pneumonia. Dr. P. saw the case six weeks after the accident occurred and found the respiratory sounds almost entirely absent over the middle and lower posterior portions of the right lung, while over the left lung loud puerile breathing and moist râles were heard. Then a suffocative attack of cough came on which reversed the physical signs mentioned above, *i. e.*, the respiratory sounds were heard over the right, while they were suppressed over the left lung. The foreign body changed its position in the trachea. The diagnosis was clear, but tracheotomy was not urged because the history showed that the patient was gradually improving. A few days after Dr. P's visit the patient coughed up a native nut-gall about the size of a pea. It was round, smooth, except where it was broken off from the twig from which it grew, and very light. The spasmodic cough never recurred after its expulsion, and the pulmonary and bronchial troubles soon vanished.

CASE XIV.—E. R., female, 2 years old, inhaled a grain of corn; symptoms were distressing at first but became less urgent in about two hours. Dr. P. saw the case forty-eight hours after the accident, when it was sleeping and respiration only slightly more rapid than normal. Respiratory sound in the left lung obtunded, with loud puerile breathing in the right lung. The dangers of letting a foreign body remain in the windpipe were explained to the parents as well as the perils of tracheotomy. They consented to the operation as it was right; the child being asleep and quiet and in no immediate danger, I determined to leave the house and return the next morning for the purpose of opening the trachea. Not long after Dr. P. left the house the child awoke with a fit of coughing and suddenly expired, the grain of corn being wedged in the rima glottidis. Dr. P. says: "Had I done as I have determined to do in the future a life would have been saved, and I would not be recriminating myself for failing to do my duty."

C. J. L.

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#### POLYPOID DISEASE OF THE NASAL CHAMBERS.

Dr. E. B. Gleason (*American Lancet*) divides nasal polypi into three classes: mucous, fibrous and cystic polypi. Cystic polypi are extremely rare. He quotes a case reported

by Cruveilhier and referred to by Bosworth, where the membranes of the brain protruded into the nasal chambers and resembled nasal polypi; an autopsy cleared the nature of the case. Polypi are almost invariably attached to some part of the ethmoid bone. Etiology: Any irritation of the mucous membrane, especially when associated with defective nasal drainage, caused by deflected septum, ecchondroses, or hypertrophies of the inferior turbinated body, but most frequently polypi are caused by diseases of the ethmoid bone (necrosing ethmoiditis, Woakes).

The disease begins with hypertrophy of the middle turbinated bodies, which, during attacks of acute coryza, press on the septum and produce neuralgia; there is also pain about the eye, congestion of the conjunctiva and epiphora. The neuralgia during the attacks of coryza may be alleviated by applying to the nostril a piece of cotton saturated with a 4 per cent. solution of cocaine. Cocaine does not produce anæsthesia as well and as quickly when the mucous membrane of the nose, eye, or tympanic cavity is inflamed as when it is not.

After applying the cocaine, the parts should be sprayed with a 4 per cent. solution of analgesin and afterwards with a 3 per cent. solution of menthol in olive oil, to prevent the return of the swelling and inflammation which, otherwise, would be greater than before the application of cocaine. A nasal suppository containing one-eighth of a grain of cocaine and one-sixteenth grain each of analgesin and menthol in ten grains of cocoa butter may be prescribed for patient's use at home, at intervals sufficiently frequent to maintain contraction of the inflamed tissue and diminish the discharge. During the first stage of necrosing ethmoiditis certain reflex symptoms are present such as, acneiform rashes on nose or face, nasal chorea affecting the orbicularis and adjacent facial muscles, slight conjunctivitis, asthenopia, photophobia and lachrymation. The radical treatment of the first stage of necrosing ethmoiditis consists in the removal of a portion of the diseased middle turbinated body, with a properly constructed Jarvis snare. When a necrosing ethmoiditis does not terminate in polypus, it usually leaves a cleft through which bony spicules are exfoliated and the disease finally cured. Reflex asthma, petil and grand mal are common at this stage of the disease.

Fibrous polypi degenerate readily into sarcomata. They often grow to a large size and send processes into the accessory nasal cavities and cause broadening of the bridge of the nose and the deformity called "frog face."

Mucous polypi are soft, gelatinous and symmetrical.

Mucous and fibrous polypi in the nose have a pinkish color and a pearl lustre.

Nasal polypi are removed with a Jarvis snare, after cocaine-ization, and their removal is painless and bloodless.

Dr. Gleason cites a case of asthma due to a mucous polypus and hypertrophic rhinitis, which was cured by the removal of the polypus and the application of the galvano-cautery to the hypertrophied tissues in both nostrils.

Nasal polypi due to a necrosing ethmoiditis will invariably return until the ethmoid disease is cured.

The treatment of necrosing ethmoiditis is as follows: a dental curette or scaler suitably shaped is passed into the sinus or cleft in the turbinated body until dead bone is felt; then, with the sharp edge of the instrument, but using the utmost gentleness, the necrosed spicules of bone should be scraped away until a perfectly smooth surface is produced. The procedure is nearly bloodless and painless after cocaine-ization, but the utmost gentleness and caution should be used in all operations on the ethmoid bone. The galvano-cautery knife may be used instead of the dental curette, at a red heat. Dr. Gleason cites a case of polypi due to necrosing ethmoiditis which was completely cured after the use of the dental scraper as described above. After the removal of polypi the patient complains of loss of power to smell, and the turbinated bodies be found hypertrophied: they should be cauterized either with the galvano-cautery or chromic acid, or any piece of bone from the septum, touching the turbinated body, should be nipped off, when the loss of power of smell, asthma, shortness of breath, etc., will usually disappear.

C. J. L.

#### MENTHOL IN LARYNGEAL AND PULMONARY TUBERCULOSIS

Assendowsky (*Annales des Maladies de l'Oreille*, 2 Juin 1891) relates his experience in the treatment of twelve cases of tuberculosis of the lungs; fifteen cases of tuberculosis of the larynx, with menthol used externally and by inhalation. The results in the lung case were: an amelioration in the general condition, augmentation of appetite, expectoration easy and diminished in quantity. The remedy does not expose to renal irritation nor to hemoptysis. In the laryngeal cases the remedy applied locally acts as an analgesic, diminishes inflammation and infiltration; superficial ulcers have a tendency to heal, but not the deep ones. It is better to begin with a 10 per cent. solution and increase the dose little by little; a 40 or 50 per cent. may cause irritation. The local and general treatment should be associated.

C. J. L.



## Book-reviews and Notices.

*A Practical Treatise on Disease of the Skin.* By Henry G. Piffard, A. M., M. D., Clinical Professor of Dermatology, University of the City of New York; Surgeon in charge of the New York Dispensary for Diseases of the Skin; Consulting Surgeon to Charity Hospital; Consulting Surgeon to the Bureau of Out-Door Relief, Bellevue Hospital; Consulting Dermatologist to the Board of Health, etc. Assisted by Robert M. Fuller, M. D., with full-page original plates and thirty-three illustrations in the text. New York: D. Appleton & Company, 1891.

Dr. Piffard is nothing if not original. He now appears before the public with an atlas of skin diseases, the illustrations of which are photographs taken by himself with the aid of artificial light, which the author's experience leads him to prefer for this purpose to ordinary daylight.

Many of these plates are remarkably true to life, besides being excellent examples of the diseases represented.

The greatest success is attained in those diseases accompanied by papular or tubercular projections, where light and shade can illustrate the character and extent of the lesions. An apparent exception to the fact that flat lesions are not well shown in the illustration of seborrhœal eczema, facing page 120. In this flat eruption, the gradual deepening of shades gives a clear idea of the character of the lesion. The author, accepting Unna's excellent description of this affection, can not agree to calling it an eczema, and proposes the name of *sudorrrhœa*.

Two illustrations rarely found in other atlases, or indeed elsewhere, are well represented here. One is Paget's disease of the nipple, called by the author, *mammillitis maligna*, and the other is *psorosperinosi*s.

The work is not at all an exhaustive one. The subject of pathological histology is entirely omitted, but the valuable illustrations contained therein make it a question with the surgeon and specialist not so much whether he will get the book as whether he can afford to do without it.

H. W. B.

*Origin, Purpose and Destiny of Man, or Philosophy of the Three Æthers.* By William Thornton, Boston, 1891. Published by the Author.

Under the foregoing high-sounding title, man's origin and destiny are discussed—or at least, occasionally alluded to. The author has some exceedingly original views and endeavors to show how medicine may be made a science. As empiricism prevails in every branch, we must endeavor to formulate medicine rationally. Disease arises from defective nutrition, and this should be remedied by returning to the body pabulum composed of chemical elements found normally there. Other substances, such as lead, mercury, digitalis, nux vomica and most of the common drugs of the pharmacopœia are incompatible.

The author claims to have made certain discoveries in diabetes mellitus and other diseases leading to a cure of them, but omits to give this formula. If this be so, he has done the profession and humanity a great injury. We regret this omission, for the practical and useful side of this work is thereby entirely lost.

H. W. B.

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*Twelve Lectures on the Structure of the Central Nervous System, for physicians and students.* By Dr. Ludwig Edinger. Second revised edition, with 133 illustrations, translated by Willis Hall Vittum, M. D., and E. Eugene Riggs, A. M., M. D. Philadelphia: F. A. Davis, publisher, 1890.

This is a good translation of a standard work on the central nervous system. The lectures open with a brief, but interesting review of the history and methods of investigating the central nervous system. The embryology and comparative anatomy take up seventeen pages of the book, and are presented in as interesting a way as the difficulties of such intricate subjects will permit. Then the various parts of the brain are taken in their order, and described very accurately and minutely. The illustrations are numerous and well executed. There is one feature, however, which may be objectionable to American students, who are not familiar with German, namely, the German names of the parts in the illustrations. The references are not by figures, but the German names are engraved in the figures. Beneath each figure, English equivalents for the German names are given, so that the difficulty is one which will not cause any great loss of time or labor.

A. McS.

*Collected Contributions on Digestion and Diet.* By Sir Wm. Roberts, M. D., F. R. S. (Lea Bros. & Co., Philadelphia).

This book mainly consists of the Lumleian Lectures "On the Digestive Ferments and Artificially Digested Food," delivered by the author before the College of Physicians in 1880, and a course of five lectures "On Dietetics and Dyspepsia," given at the Owens College in 1885. The author has also put in all of his other contributions on Digestion, Dietetics and Dyspepsia. He divides his work into four general sections, as follows:

1. Digestion and the Digestive Ferments.
2. Dietetics.
3. Preparation of Food for Invalids.
4. The Acid Dyspepsia of Healthy Persons.

He then subdivides these sections into many subdivisions and writes of them in detail. The whole work shows that the author has been a careful observer, and is so well written and practical, that everyone should have it

W. E. P.

*Surgical Bacteriology.* By N. Senn, M. D., Ph. D., Professor of Surgery in Rush Medical College, etc. Second edition, thoroughly revised. Philadelphia: Lea Bros. & Co, 1891. (New Orleans: Hawkins & Co., 194 Canal Street. \$2.)

The second edition of this valuable work incorporates all the advances made in bacteriology in relation to surgery. A surgeon can not be such without being a pathologist, and bacteriology is now an essential part of modern pathology. Not all men who would be enlightened surgeons can afford the time to become accomplished bacteriologists. The facts in bacteriology that bear upon surgery are scattered through a vast mass of literature. The labor of selecting them and arranging them in a systematic manner is one that involves profound erudition and great labor. The work before us attests the learning and diligence of the Milwaukee surgeon; and the rapid exhaustion of the first edition shows how fully the surgeons of our country appreciate the merits of the book. Senn has placed American surgeons under a lasting obligation for the clear and masterly manner in which he has given them the facts that will enable to form accurate ideas of surgical pathology.

A. McS.



## State News and Medical Items.

[Communications from Physicians of Louisiana are solicited for this Department. News of personal interest is especially desired.]

### CHARITY HOSPITAL.

The regular meeting of the Board of Administrators of the Charity Hospital was held on August 4, 1891, and the Board was re-organized, the personnel remaining the same, with the exception of the new appointee, Mr. Geo. Seeman, who took his seat.

Vice President Bickham called the meeting to order. There were present: Col. W. G. Vincent, J. H. Keller, George Seeman, Hugh McManus and Secretary Edwin Marks.

The chairman explained that the meeting was one at which the newly commissioned members of the board would present their credentials, and that it was necessary to reelect the officers of the board.

He was nominated to succeed himself, and Col. Vincent, who was called to the chair, put the motion, which was carried.

After resuming the chair, Dr. Bickham expressed his thanks for the honor done him, and with a few appropriate remarks he called for nominations for the remaining offices. The election was then proceeded with, with the following results:

Dr. A. B. Miles, house surgeon; Dr. J. D. Bloom, assistant house surgeon; Edwin Marks, secretary and treasurer; Dr. H. D. Bruns, pathologist; John Johnson, chemist and druggist; J. C. De Mahy, clerk; John Ponder, engineer; Dr. S. P. Delaup, assistant pathologist.

The regular order of business was then taken up, and under that head Secretary Marks read a letter from the firm of attorneys representing the Switzer estate, in which the tidings were conveyed to the board that the sum of \$20,000 had been left by the deceased with the proviso that Mrs. Switzer would have the usufruct of the legacy during her life. Mr. Marks stated that he had called on the firm of attorneys who informed him that as the lady was possessed of considerable means there was every good chance of her relenquishing her claim to the usufruct and allowing the legacy to go to the hospital.

The news was of a very agreeable nature, and the mem-

bers of the board expressed their hearty appreciation of the timely remembrance of the institution by a vote of thanks.

Secretary-Treasurer Marks read his report for the month of July, showing the financial status of the institution. The receipts during the month amounted to \$49,950.24 and the disbursements for the same period were \$7471.81, leaving a balance on hand of \$42,478.43.

Mr. Marks announced that, with the approval of the board, he would offer Messrs. John T. Gibbons, Col. A. W. Hyatt and Major Andrew Hero as sureties on his bond. These sureties were accepted by the board on motion of Col. Vincent.

In making his report, Dr. A. B. Miles, house surgeon of the Hospital, prefaced his remarks by returning thanks to the Board of Administrators for their kind favor in reelecting him to the position which he had occupied for years. The other members of the medical staff of the hospital joined with Dr. Miles in his return of their thanks, and through him they pledged themselves to serve the institution with conscientious attention.

Continuing his remarks, and touching on the affairs proper of the hospital, Dr. Miles said that all the reports from the special departments had been approved by him. There was about the usual number of patients in the hospital, and there was, he said, no epidemic diseases prevailing. Dr. Miles stated that applications for leaves of absence had been made to him in regular form by Dr. J. Moore Soniat, to replace whom no one had been selected; Dr. Paul Michinard, whose place will be filled by Dr. Lamb; and Dr. John Laurans, for whom no substitute had been found. Dr. Miles said that if no member of the hospital staff would take Dr. Laurans' ward he would attend to it himself. In conclusion, Dr. Miles asked for a month's leave of absence for Dr. Bloom, his assistant, who would leave first, to be followed later by himself.

On motion of Mr. McManus, the applications were all agreed to, and Vice-President Bickham stated that Dr. Bruns had made application to him for a leave of absence to go to Virginia, where his family were summering. Dr. Bruns had informed him that there was sickness in his family, and as the case was an urgent one, Dr. Bickham said he had given Dr. Bruns leave of absence for two months.

Mr. McManus moved an approval of Dr. Bickham's action, but Col. Vincent was inclined to object on account of the application not having been sent through the usual channel. He argued that the action was a disregard of the courtesy due the board and the house surgeon.

Mr. McManus took exception to the remarks of Col.

Vincent, and held that as Dr. Bickham had given the case his attention there was no further use of discussing the matter.

The vote was taken and Dr. Bruns' leave of absence was approved, Col. Vincent remarking that in the future he would oppose all applications which did not come through the proper channels.

Taking up the thread of his remarks, Dr. Miles said that in conformity with the resolution passed at the last meeting of the board he had drafted a set of rules for the governing of the outdoor clinic, now in course of preparation. The doctor stated that he did not wish to have the rules published as yet, as it would be a little premature. He said that he could furnish the gentlemen of the board with copies of the rules if such was the desire of the board. It was decided to have printed copies of the rules submitted to the members, who could make such amendments thereto as they would see fit.

Dr. Miles then read the following rules for the ambulance service:

1. The ambulance service, constituting a part of the medical department, shall be conducted under the general rules governing the hospital.

2. This shall be an emergency service, intended more especially for cases of sudden illness or injury.

3. An ambulance will be dispatched to any part of the city, at the call of patrons of the service, physicians, the city police, the fire department, or other responsible source, subject to the approval of medical officers of the hospital.

4. The ambulance on a call shall be attended only by members of the ambulance corps, in uniform and wearing a badge of the service.

5. The driver shall have special care of the ambulance, its equipments and the horses, and shall keep the harness in good order. He shall not leave his seat while in actual service.

6. The ambulance surgeons shall have executive control when on duty. They shall administer on the spot such temporary treatment as may be necessary, and except in cases specified below, convey patients without delay to the hospital.

- (a). The ambulance shall not receive cases of smallpox or other patients rejected by the rules of the hospital, for instance those whose condition is not serious enough to warrant admission.

- (b). Cases of emergency may be removed to their home or place of lodging, without charge, when they can not afford the fee.



7. The duties of the ambulance surgeon are strictly medical, and when out on a call they shall not give opinions bearing on medico-legal questions.

8. Upon return of the ambulance to the hospital the medical attendant shall supervise the removal of patients to the ward or operating room, and then report to the house surgeon or to the assistant. It shall also be his special duty of the day to record in the clinical notebook of the ward or the amphitheatre register his knowledge of the patient's disease or injury, and the preliminary treatment adopted.

9. In all doubtful questions regarding their duty the ambulance surgeons are instructed always to pursue the course that inclines to the side of humanity.

10. The ambulance may be hired by responsible persons and for suitable purposes; for instance, the conveyance of patients between steamboat landings, railroad depots and the hotels, for \$10, the amount thus accruing to be delivered to the treasurer and credited to the fund of the service.

11. The ambulance relief fund created by resolution of the Board of Administrators and aided by the contributions of patrons, shall be devoted exclusively to establishing and maintaining this service, and enhancing its usefulness as a public charity.

12. Subscriptions will be duly acknowledgee by the secretary and treasurer of the hospital.

Following the rules appears the ordinance (No. 978, C. S., adopted October 30, 1884), giving the ambulances the right of way through the streets. It was decided that a number of copies should be printed, and that they be placed in prominent parts of the city.

The following report for July, 1891, was then read: Number of patients in hospital July 1, 559; number of patients admitted, 537; foreigners, 168; United States, 369; males, 401; females, 136; number of patients discharged, 479; males, 354; females, 125; number of deaths, males, 51; females, 17; total, 68; number of patients in hospital August 1, 1891, males, 350; females, 199; total, 549; daily average of patients for month, 561.

A lengthy discussion as to the plans for the new buildings to be used for the out-door clinic was then indulged in, and the board resolved to make the matter the subject for a special meeting to be held on Thursday next at 7: 30 o'clock.

Nothing further being before the board, it was declared adjourned, and an executive session was held.—*Times Democrat*.

DRS. LAYTON AND SURGHNOR, of Monroe, La., have organized an out-door clinic. It is meeting with success, and it has an average of forty patients at each clinic. They report good results with Koch's Lymph, in *local* tuberculosis. An infirmary will be built in September, with fifteen beds.

DR. JULIUS F. SCHMITTLE, of New Orleans, has returned to the city.

DR. WILLIAM SCHUPPERT is the guest of Dr. and Mrs. Von Gohren, of Bay St. Louis, Miss.

DR. LOEBER is an evidence of what Bay St. Louis air can do. His health has been greatly improved.

DR. R. W. FAULK has moved to Monroe, from Texas.

DR. R. L. LUCKETT, junior class of 1891, was elected a member at the last meeting of the Rapides Parish Medical Society.

DR. H. DICKSON BRUNS has gone to Virginia, to spend a few weeks. He will return by October 1.

DR. A. DE SEAY, of Ruston, takes an active interest in fostering the spirit of medical organization. He has been elected president of the Lincoln Parish Medical Society.

DR. C. A. CHANDLER, of New Orleans, spent his vacation at Covington, La.

DR. C. M. SMITH has returned to Franklin from a pleasant trip to Virginia.

DR. W. F. PEARSON, of Alabama, has settled in Houma, La.

DR. R. B. HOOPER, of Timpson, Tex., who has been staying in New Orleans since last February, has returned to his old home.

DR. ERNEST LAPLACE, formerly of New Orleans, paid a visit to the city of his birth last month. He left on August 17 to be in readiness to resume his arduous duties as professor of Pathology and Clinical Surgery in the Medico-Chirurgical College of Philadelphia.

PROF. E. S. LEWIS has returned to New Orleans, after a holiday spent in the Catskill Mountains.

Dr. C. M. FISHER, of Shreveport, has been a constant reader of the JOURNAL for many years. It is gratifying to learn that the recent changes introduced have impressed our old friend agreeably.

Dr. J. P. RUNYAN has returned after a month spent in Arkansas.

Dr. J. A. K. BURCHETT, of Vicksburg, Miss., was in the city last month.

Dr. SILVA JARDIN, of Rio de Janeiro, met with a terrible death—by falling into the crater of Vesuvius.

GOVERNOR NICHOLLS has appointed Dr. Geo. K. Pratt a member of the State Board of Health of Louisiana, vice Dr. Henry Bezou, resigned.

Mr. JOSEPH T. SCOTT, JR., son of Dr. T. J. Scott, has been appointed resident student of the United States Marine Hospital, of this city, in place of John Archinard, resigned. Mr. Scott is a student at Tulane University.

Dr. H. HAYWARD has returned from a short vacation in Georgia.

THE REMAINS OF DR. JAS. F. HEUSTIS INTERRED AT MOBILE.—The funeral of Dr. James F. Heustis, Mobile, took place on August 30 from St. John's church, Rev. G. C. Tucker officiating. There was a large attendance and many handsome floral emblems. The medical faculty attended in a body, as did the orphans of the Church Home, of which institution he was physician. The interment was in Magnolia cemetery.

Dr. G. FRANK LYDSTON has been elected to the Chair of Genito-Urinary and Venereal Diseases at the Chicago College of Physicians and Surgeons. Dr. Lydston's contribution to the literature of this special branch of study, have made him so well known that the college and its classes are to be congratulated on the appointment made.

Dr. J. L. CUNNINGHAM has been elected president of the Fort Worth Medical Club.

THE MEDICAL DEPARTMENT OF THE UNIVERSITY OF TEXAS.—This institution, located in Galveston, will open the



coming fall with nine professors, and will give three years' graded course of instruction of eight months each. We learn from the *Virginia Medical Monthly* that the pay of each professor will be, on an average, \$3,000 each session. The President of the Board of Regents is Dr. Thomas D. Wooton, of Austin. The College and Hospital will occupy adjacent blocks in Galveston, immediately upon the gulf and bay. It is the determination of the Regents to make this a truly leading school of medicine in every respect, and to allow none to graduate from it who are not deemed worthy of diplomas.

A NEW BUREAU.—Secretary of Agriculture, Rusk has recently put in working order his new bureau in Chicago for the microscopic examination of hog products for export. He selected a corps of thirty microscopists, fifteen men and as many ladies, and they were set to work under the direction of Drs. John Michels, of New York, and F. H. Bernard, of Pittsburg—microscopical experts. The force will be increased until it is large enough to examine a piece of the diaphragm and of the tenderloin of each hog killed. Those found to be diseased will be condemned.—*Science*.

DR. BRINTON, so long known for his surgical work, and his former connection with the *Philadelphia Medical and Surgical Reporter*, has received the degree of LL.D. from the Jefferson Medical College in recognition of his researches in anthropology and ethnology.

SURGEON JOHN GODFREY, M. H. S., was appointed to represent the service at the Seventh International Congress of Hygiene and Demography, at London, July 25, 1891; detailed as member Board of Examiners August 8, 1891.

PASSED ASSISTANT SURGEON H. R. CARTER was granted leave of absence for thirty days, August 8, 1891.

SIR MORRELL MACKENZIE, the celebrated throat specialist of London, has brought suit for \$10,000 damages, for the alleged unauthorized use of his name, against the Soden Mineral Springs Company and the Eisner & Mendelson Company. An injunction has been asked for.

CREMATION FLOURISHES IN JAPAN.—Tokio has six crematories, in which the bodies of at least one third of the dead are

burned. In 1888, 11,023 of the 34,437 persons who died were cremated, and since burial in the city has been forbidden, the number has increased. According to the style of cremation, the price is \$3.75, \$2, or \$1. Sixty-six pounds of wood, which costs approximately 25 cents, suffices for the burning of a body in three hours.—*Clin. Rep.—Courier of Medicine.*

**DANGEROUS PETS.**—A French scientist declares that the domestic pets of the world carry at least 30 per cent. of the common contagious diseases from house to house.—*Am. Analyst.*

THE first number of the *Apothecary*, published by the Illinois College of Pharmacy, has been received. *The Apothecary* is a quarterly journal, devoted to pharmacy, chemistry, botany, materia medica, metrology, and to pharmaceutical education and progress.

By the will of the late Dr. Fordyce Barker, the New York Academy of Medicine is to receive all the works in his library relating to obstetrics, gynæcology, and the diseases of children.

The lunatics and diseased persons sent back to Europe from the State of New York during the last seven years numbered in all, 1374.

Medical men have occasion to know that but a small percentage of the diseased and dependent classes are returned to their homes. One-third of our insane are foreign born, as is also over one-half of our dispensary and hospital population.

“Doctor,” said a grateful patient, seizing the physician’s hand, “I shall never forget that to you I owe my life.” “You exaggerate,” returned the doctor mildly; “you owe me for only fifteen visits. That is the point I hope you will not fail to remember.”—*Exchange.*

There are altogether in the United States and Canada forty-seven faculties of medicine which receive students of both sexes, and nine devoted to the medical education of women exclusively.

The late Dr. Yandell, of St. Louis, was fond of telling the following joke on himself: A lady patient of his, on entering his consultation room one morning, greeted him with the remark: “Doctor, I had such a singular dream about you

last night." "Indeed," said the doctor, "what was it?" "Why, I dreamed that I died and went up to heaven. I knocked at the golden gate, and was answered by St. Peter, who asked my name and address, and told the recording angel to bring his book. He had considerable difficulty in finding my name, and hesitated so long over the entry when he did find it, that I was terribly afraid something was wrong, but he suddenly looked up and asked, 'What did you say your name was?' I told him again. 'Why,' said he, 'you've no business here. You're not due this ten or fifteen years yet!' 'Well, said I, 'Dr. Yandell said—' 'Oh, you're one of Yandell's patients, are you?—that accounts for it. Come right in! come right in! that man's always upsetting our calculations in some way.'"

The county commissioners of Cook County, Illinois, have appropriated \$80,000 for two new pavillions at the Cook County Hospital, \$35,000 for a Morgue, \$40,000 for a Detention Hospital for the insane, and \$40,000 for detached wards for contagious diseases. Plans are perfected and building will go rapidly on, that for the Detention Hospital and Morgue being well under way.

It is a sad comment upon our boasted civilization for Chinese quacks to be patronized by our people; yet such is the case in our most enlightened centres. We send our missionaries to China to preach to the heathens, and at the same time the heathens are here among us with their lizard juice and pulverized bugs and worms, for which they find a ready demand from a class of people who claim "the Chinese should be civilized."—*Ex.*

Human milk was recently examined at, and reported from Tokyo (Japan) Sanitary Laboratory, and shows that the milk of Japanese women contains less nitrogenous matter and ashes, and proportionately larger amount of carbo-hydrate than that of European. This is probably due to the consumption of rice in Japan.—*Sei-i-Kwai.*

The September number of the *New England Medical Monthly* is a souvenir number, issued to celebrate its tenth birthday. The enterprising editor, Dr. Wm. C. Wile, has



gathered the pictures of many doctors from all parts of the country; and the souvenir number, in addition to containing the usual amount of valuable reading matter, is a veritable picture gallery of contemporaneous medical men of eminence. The JOURNAL wishes the *Monthly* continued prosperity.

THE Alvarenga Prize for 1891, of the College of Physicians of Philadelphia, has been awarded to Dr. L. Duncan Bulkley, of New York, for his essay on Syphilis Insontium.

In the southern part of "ye olden" London was the seat of eccentric Dr. I. Lettsom, one of the most successful physicians of his day. His practice was very extensive. In some years his receipts were £12,000. He is reported to have said of himself:

"When patients come to I,  
I physics, bleeds and sweats 'em,  
Then—if they choose to die—  
What's that to I—I let's 'em."

He was running a pile driver at the base of a slipping hill-side. Mose had heard of him as a most efficient man in his business, and meeting him in a saloon, said: "Boss, I's troubled awful wid de piles; what you charge to drive 'em away?"—*Gleaner*.

It is stated in *Nature* that Siam, following the example of Japan, is commencing to Europeanize her institutions. The founding of a university has been decided upon, and Prof. Haase, of Königsberg, has accepted the appointment to the chair of physics.

"Man born of woman is of few years and full of bowel-trouble."—*Solomon, Revised*.

I think many of our examining boards have met this school boy at a somewhat maturer stage of his development. He was requested to briefly name and describe the divisions of the human body and the contents of each. "The body is divided into three cavvyties, the head, thoracks and abbdomen; the head contains the brains, when there is enny; the thoracks contains the lungs, liver and diafram; the abbdomen contans the bowils, which is five in number, *a*, *e*, *i*, *o*, *u*, and sometimes *w* and *y*.

## Practical Notes and Miscellany.

### THE PROGRESS OF CHOLERA.

Cholera is still preading in Abyssinia, the disease making great progress at Massowah, where not only natives but some Europeans have been attacked. The heat is stated to be excessive. It is also alleged that some cases have occurred among pilgrims at Mecca, and that detention at Red Sea ports is already being arranged for pilgrims before returning to Egypt or passing up the Suez Canal. The occurrence of the disease at Aleppo has led to quarantine being imposed by the Austrian government on all arrivals from Syrian ports between Karatash and Latakia and the same regulation will apply to arrivals from Red Sea ports.

### TRI-STATE MEDICAL ASSOCIATION.

The third annual meeting of the Tri-State Medical Association will convene in Turner Hall, Chattanooga, Tenn., Tuesday, October 27, 1891, and continue in session three days. Indications are that it will be one of the largest medical meetings ever held in the South. Representative physicians from all sections will be present.

All who desire to read papers should send title to the secretary of the association before September 1. In due time a circular will be issued giving a complete list of all papers and names of exhibitors who apply for space before October 1.

W. L. GAHAGAN,

*Secretary of Executive Committee.*

### SEDATIVE FOR BABIES.

Dr. Van Goidtsnoven, of Atlanta, gives a formula with which he has had most gratifying results in restlessness, spasms, delirium, and in all cases requiring a sedative, anodyne, anti-spasmodic or somnifacient.

- R. Camphor, monobromat.....gr. xvi.  
 Ext. hyoscyami fl.....gtt. xvi-xxx.  
 Syrup lactucarii (Aubergier's)....f3viiij. ℥.  
 S. A tablespoonful every hour till relieved.

—*Dixie Doctor.*

## INFANTILE DIARRHCEA.

1. Withdraw all milk from twenty-four to thirty-six hours. 2. Regulate the quantity and quality of the food and the frequency of giving it. 3. Give plenty of cool water. 4. Reduce the temperature with the bath. 5. Give medicines of an antiseptic and astringent character and stimulants as needed. 6. Wash out the colon two or three times a day.—*Archives of Pediatrics*.

## IODOFORM AND ARISTOL.

Dr. Richtmann recommends (*Nouveaux Rem.*) that aristol be used to replace iodoform, since it presents all the advantages of iodine and thymol without any of their disadvantages. Aristol does not cause irritation; its absorption is not followed by any phenomenal intoxication, and its odor is not disagreeable. Being less volatile than thymol, its use is especially indicated in extensive burns. It may be prescribed as a powder, or an ointment, or given in solution. The preparations used by Richtmann are as follows:

- R<sub>y</sub>. Aristol pure.....gm. 10.  
 S. For external use.
- R<sub>y</sub>. Aristol.....gm. 1.  
 Ether.....gm. 10.  
 S. For external use.
- R<sub>y</sub>. Aristol.....gm. 2.  
 Paraffin ointment.....gm. 18.  
 S. For local application.
- R<sub>y</sub>. Aristol.....1 to 5 cgm.  
 Cocoa butter.....q. s.  
 S. For uretral or vaginal bougies.

—*Medical Standard*.

## PHENACETIN IN SCIATICA.

Sciatica is not only one of those affections which are extremely annoying and painful to the patient, but on account of its persistency often greatly tries the patience of the physician. At the clinic of Prof. Landon Carter Gray most benefit has perhaps been obtained from phenacetin, given, say, in tablets of four to eight grains every three or four hours. There are a good many cases, however, which do not respond to it very markedly. Doubtless, too, there are many cases of scia-



ica neuritis, rheumatism, gout, etc., in which a diagnosis of sciatica is erroneously made; but perhaps more frequently sciatica is mistaken for one of these affections.—*Practice*.

#### BISMUTH FOR ECZEMA OF INFANTS.

The following formulæ is given in *Nouveaux Remèdes*:

R<sub>y</sub>. Bismuth. subnit.....℥v.  
 Zinci oxidi.....℥iss.  
 Acidi carbolici.....m. x.  
 Vaseline.....℥j. m.

To make an ointment.

In case there is much irritation paint on the following with a soft brush:

R<sub>y</sub>. Bismuth. subnit.....gr. xl.  
 Glycerine.....℥ijss.  
 Acidi carbol.....gtts. vj.  
 Aquæ rosæ.....℥iv. m.

To be well shaken.

#### ACUTE BRONCHITIS.

The citrate of potassium is a favorite remedy of Dr. H. C. Wood in acute bronchitis; his formula is, he says, the most reliable and efficient sedative cough mixture that he has ever used:

R<sub>y</sub>. Potass. citrat.....℥j.  
 Suc. limonis.....℥ij.  
 Syr. ipecac.....℥ss.  
 Syr. q. s. ad.....℥vj. m

Sig. A tablespoonful four to six times a day.

Another favorite expectorant with this writer is oil of eucalyptus, which may be given in five minim capsules every three hours. It is not only of use after expectoration is established.

#### MOUTH WASH.

David uses the following mixture as a tonic and antiseptic mouth wash (*Medical News*, February 21, 1891):

R<sub>y</sub>. Thymol.....7 grs.  
 Borax.....15 grs.  
 Water.....1 ½ ozs. m.

A few drops of this are to be placed in wineglassful of warm water, and the mouth rinsed with it. In cases in which the breath is fetid, owing to deposits about the tonsils and gums, the following wash is said to be serviceable :

R. Borate of sodium.....15 grs.  
 Alcohol..... $\frac{1}{2}$  drachm.  
 Water.....1 pint.  
 Thymol.....7 grs. M.

Dr. W. B. Rogers, an editor of the *Memphis Journal of the Medical Sciences*, unburdens his weary soul in the following strain :

BOB-TAILED MEDICAL DIRECTORY.—A new directory has recently been put off on the unsuspecting medical profession of the Southern States, and lest the same fraud is being prepared for other sections, I present a few points worthy of note concerning the *Southern Medical Directory*.

The title page reads: "Physicans, Dentists and Druggists' Directory of Alabama, Georgia, Louisiana, Mississippi, South Carolina and Tennessee—Comprising List of Physicians and Surgeons, Dentists and Druggists, arranged alphabetically, by postoffices, etc. Galen, Gonser & Co., publishers, New Orleans, La. 1891. Price \$2, complete in one volume."

I have not investigated with reference to dentists and druggists, but am free to say it is an *incomplete list of the physicians* in the Southern States—since it contains but about one-third the number of names in these States, as furnished by *Polk's Directory*. That the directory was not compiled by G. Gonser & Co. within the past year is evident. This I can say because I can point out names of men whose location has been changed from that given for four on to five years; some by reason of death, others, removal to other states; others by sojourn in lunatic asylums. It is what might be termed a "short horse" directory.

My attention was called to this directory while yet ostensibly in preparation, by a canvasser who solicited the card of an institution with which I am connected, for publication among the "ads." After several visits and much annoyance to me, this canvasser secured my signature for contract for ad. and for the book on the following conditions:

1. The number of ads. was limited to thirty.
2. None but cards of recognized reputable institutions and men, were to be admitted in the book.
3. My card was to occupy page opposite index.

4. It was to contain the names of all the physicians of the states named, and five-sixths of the physicians of Mississippi were guaranteed as subscribers to the book—names of those subscribing would appear in bold type.

In due time the book was presented, together with bills—I declined to receive the book or pay the bills:

1. Because the book contained sixty-five ads. instead of thirty.

2. Because the book contained among these sixty-five ads. the cards of at least four recognized secret nostrums, bunco men.

3. Three pages has been cut out to bring my card up to face index (stubs left in *situ!!!*)

4. It was too apparent that the directory did not contain the names of half the physicians in these States. And, on sketching it, I found many towns omitted, and some names in bold type of parties whose residence had been changed for years.

These points were shown the canvasser who gave me *his* word of *honor* that only in the first hundred printed was my card misplaced. He tried manfully to convince me that the book was up to contract, until finally I urged him to leave—he left.

I have since taken occasion to address a line to eighteen members of the profession in Mississippi and Tennessee whose names appear in bold type. Eighteen answers to a unit, “have never seen or heard of any canvasser or representative of the book.” I have also several copies from my friends in Georgia, South Carolina and Tennessee, and find there has been no hesitancy about cutting out pages to bring a desired ad. to preferred space.

I also took occasion to address two letters to Galen Gonser & Co., New Orleans, La., asking the name of the gentleman with gall who had obtained my ad., but no reply have I had. Another letter to Galen Gonser & Co., Chicago, the address given me by Boland & Co., St. Louis, has failed to obtain any reply. The chief of police of New Orleans writes me there is no such firm of publishers known there among publishing houses.

Now, what are we to conclude? Is it possible that a sharper has copied a limited portion of *Polk's Directory*, and is gulling the profession in various sections? It looks that way; and not being out any money, I take the liberty of warning the profession.

W. B. ROGERS.



## MORTUARY REPORT OF NEW ORLEANS.

FOR JULY, 1891.

CAUSE.	White .....	Colored .....	Male .....	Female .....	Adults .....	Children .....	Total .....
Fever, Yellow .....							
“ Malarial (unclassified)....	6	5	7	4	4	7	11
“ Intermittent .....	2	1	3		2	1	3
“ Remittent .....	7	2	3	6	7	2	9
“ Congestive .....	2	2	2	2	1	3	4
“ Typho-Malarial .....	3	7	6	4	9	1	10
“ Typhoid or Enteric .....	5	2	3	4	5	2	7
“ Puerperal .....	1			1	1		1
Scarlatina .....							
Small-pox .....							
Measles .....							
Diphtheria .....	2		1	1		2	2
Whooping Cough .....							
Meningitis .....	8	4	4	8	5	7	12
Pneumonia .....	12	5	11	6	8	9	17
Bronchitis .....	5	2	4	3	3	4	7
Consumption .....	25	31	27	29	56		56
Cancer .....	8	3	5	6	11		11
Congestion of Brain .....	7		5	2	1	6	7
Bright's Disease (Nephritis) ..	13	8	14	7	20	1	21
Diarrhœa (Enteritis) .....	24	21	24	21	19	26	45
Cholera Infantum .....	19	7	16	10		26	26
Dysentery .....	2	1	2	1	3		3
Debility, General .....	3	1	1	3	4		4
“ Senile .....	15	6	8	13	21		21
“ Infantile .....	3	9	6	6		12	12
All other causes .....	173	83	151	105	162	94	256
TOTAL .....	345	200	303	242	342	203	545

Still-born Children—White, 29; colored, 11; total, 40.

Population of City—White, 184,500; colored, 69,500; total, 254,000.

Death Rate per 1000 per annum for City—White, 16.30; colored, 34.53.  
total, 24.61.HENRY WILLIAM BLANC, M. D.,  
Chief Sanitary Inspector.

## METEOROLOGICAL SUMMARY—JULY.

STATION—NEW ORLEANS.

Date.....	TEMPERATURE.			Precipn. in inches and hundredths..	SUMMARY.
	Mean	Max.	Min.		
1	81	87	75	.03	Mean barometer, 30.04.
2	82	89	74	0	Highest barometer, 30.18, 24th.
3	80	84	76	.06	Lowest barometer, 29.89, 7th.
4	78	83	73	.01	Mean temperature, 81.
5	76	83	70	.94	Highest temp., 92, 15th; lowest, 79, 9th.
6	76	84	68	.95	Greatest daily range of temperature, 17, 23rd.
7	79	84	74	.51	Least daily range of temperature, 7, 9th.
8	84	89	78	T	MEAN TEMPERATURE FOR THIS MONTH IN—
9	76	79	72	.04	1871.....84.0    1876.....83.0    1881.....84.0    1886.....80.0
10	78	85	70	0	1872.....82.0    1877.....83.0    1882.....80.0    1887.....80.0
11	80	86	73	0	1873.....82.0    1878.....84.0    1883.....84.0    1888.....82.0
12	82	89	75	0	1874.....81.0    1879.....83.0    1884.....85.0    1889.....83.0
13	80	86	74	.31	1875.....82.0    1880.....81.0    1885.....83.0    1890.....82.0
14	84	91	76	0	1891.....81.0
15	84	92	77	0	Total deficiency in temp'ture during month, 41.
16	82	87	76	.11	Total deficiency in temp'ture since Jan. 1, 83.
17	84	91	76	T	Prevailing direction of wind, S. E.
18	83	90	76	0	Total movement of wind, 5531 miles.
19	83	90	76	.07	Extreme velocity of wind, direction, and date,
20	81	87	75	.10	38 miles, from S. E., 6th.
21	82	88	75	.01	Total precipitation, 4.57 inches.
22	84	90	77	0	Number of days on which .01 inch or more of
23	84	92	75	.26	precipitation fell, 18.
24	80	88	73	.23	TOTAL PRECIPITATION (IN INCHES AND HUNDREDTHS)
25	79	86	72	.34	FOR THIS MONTH IN—
26	82	88	75	.29	1871.....4.34    1876.....4.73    1881.....6.97    1886.....4.35
27	82	90	75	.07	1872.....6.43    1877.....6.41    1882.....6.84    1887.....7.88
28	81	88	74	.25	1873.....5.22    1878.....6.21    1883.....3.33    1888.....2.02
29	84	90	77	0	1874.....12.93    1879.....7.04    1884.....4.12    1889.....9.13
30	84	91	77	0	1875.....6.57    1880.....11.22    1885.....6.15    1890.....6.59
31	84	91	78	T	1891.....4.57
					Total deficiency in precip'n during month, 1.94.
					Total deficiency in precip'n since Jan. 1, 15.48.
					Number of clear days, 7; partly cloudy days,
					18; cloudy days, 6.
					Dates of Frost, .....
					Mean maximum temperature, 88.0.
					Mean minimum temperature, 75.0.

NOTE.—Barometer reduced to sea level. The T indicates trace of precipitation.

G. E. HUNT, *Local Forecast Official.*

## SYNOPSIS OF SUMMARY FROM SHREVEPORT, LA.

Mean barometer, 29.986.

Highest barometer, 30.153, 24th.

Lowest barometer, 29.654, 6th.

Mean temperature, 80.5.

Highest temperature, 96, 14th; lowest temperature, 64, 9th.

Greatest daily range of temperature, 26; 3d.

Least daily range of temperature, 5, 8th.

Prevailing direction of wind, S. E.

Total movement of wind, 4031 miles.

Extreme velocity of wind, direction, and date, 30, S. E., 4th.

Total precipitation, 2.57 inches.

Number of days on which .01 inch or more of precipitation fell, 6.

Total deficiency in precipitation during month, 1.17.

Total deficiency in precipitation since January 1, 13.08.

Number of clear days, 15; partly cloudy days, 13; cloudy days, 3.

Dates of frost, —.

Mean maximum temperature, 89.6.

Mean Min., 71.4.

M. J. WRIGHT, JR., *Observer.*

Do not fail to read our Proposition at the bottom of page.4

# THE MOST PERFECT ARTIFICIAL INFANT FOOD.

It goes without saying that a child, to be perfectly nourished, should be fed on healthy human milk, or its equivalent, during the nursing period, or at least until seven months of age. If a child under seven months of age **must** be **artificially** nourished,

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As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, physicians are earnestly requested, when prescribing the Syrup, to write "Syr. Hypophos. *Fellows.*"

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles; the distinguishing marks which the bottles (and the wrappers surrounding them) bear, can then be examined, and the genuineness—or otherwise—of the contents thereby proved.

*Medical Letters may be addressed to:*

Mr. FELLOWS, 48 Vesey St., New York.

October, 1891.

*Paullum sepulture distat inertiæ  
Celata virtus.*—HORACE.

# New Orleans Medical and Surgical Journal.

Augustus McShane, M. D.,

Editor and Publisher.

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# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

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## Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the first day of the month preceding that in which they are expected to appear. A complimentary edition of twenty-five reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a *written* order for the same accompany the paper.]

### CHAULMOOGRA OIL IN THE TREATMENT OF LEPROSY.

By PHILLIPPE BERGE, M. D., NEW ORLEANS, LA.

Notes on the treatment of disease are always welcomed by the progressive physician, and I trust my results in the medication of leprosy will be viewed with a critical eye, pondered upon well; and adjudged impartially by all well-thinking medicos.

It is true that my experience is very limited, but the effects of the chaulmoogra treatment have been so marvelous that I deem it an imperative duty to impart the knowledge of the same to the profession, without awaiting further results, so confident am I of the curative properties of the oil.

When I assumed charge of the Lazaretto I found therein four patients, one of whom died a few days afterwards. I will not give a description of the pathological lesions found on her person, since she did not come under my professional care.

CASE I. Mr. W., aged 50 years, native of Germany, resident of this city for many years, shoemaker by trade; says he has had leprosy six or seven years. When first seen by me the integument of forehead and cheeks was much infiltrated and offered a very shiny appearance, with a slight formation of tubercles on forehead. An examination of the

thorax anteriorly, and a look at the surface of the abdomen, and likewise of the legs, revealed patches of macular rash. Some of the phalanges of fingers and toes were gone, and ulceration had set in on some of the stumps.

Incomplete ankylosis of several of the smaller joints of hand, anæsthesia of hands and feet. Pruritis of the unaffected portion of the skin was a very annoying symptom. Treatment began with ten drops of chaulmoogra oil in a spoonful of water, three times daily after meals, on August 7; the dosage gradually increased five drops per week until he is now taking forty-five drops three times daily. No disturbance of digestive organs followed upon the administration of the oil, at any time; except a few days back, daily motions increased to four in number, and are now reduced to one or two. The infiltration of forehead and cheeks is entirely absorbed, and the peculiar shine is wanting; leaving the skin smooth, supple and normal in color. On the body, the infiltration of the macular rash has become absorbed, and the red color has given way slowly to light copper-colored stains. These copper-colored blotches are vanishing by degrees.

This is the manner in which I observed the gradual disappearance of the coloring matter: Many large copper-colored spots became covered with vesicles of different sizes, minute, medium and large, also sudamina. These vesicles were not confined to the areas of discolored skin, but could also be seen in the intervening healthy integument. This new sign was accompanied with pronounced itching. Within a few days desiccation followed, and with it was seen streaks of skin devoid of all pigment, producing a characteristic segmentation of the large areas of copper-colored stains, and simultaneously also a decided fading of the coloring matter.

This processus having taken place, the dimming, division and subdivision of these islets into smaller islets now continues without a return of the vesicular eruption. Incomplete ankylosis of smaller joints has given way to free mobility, a very good proof of the absorptive properties of chaulmoogra oil. Sensation has returned, to a large extent, in hands and feet. Patient gives expression to a feeling of well-being, and is

jubilant over the results, anxiously awaiting an early discharge. This man, neatly clad, could walk our prominent thoroughfares unnoticed by the most educated eye, but for a missing ala of the nose. His gait is elastic, his mind clear, and has every indication of health, except the destructive lesions antedating the treatment by the curative agent under discussion.

CASE II. Mr. J., a native of England, has lived in New Orleans for many years, a seaman by calling; just before treatment with chaulmoogra oil, his whole face was shiny, deeply infiltrated, and of a dark, livid hue, with a very decided formation of tubercles on forehead. Hands and arms of a dark tan color; and loss of sensation above the elbows. The feet were very swollen, and very painful on plantar surface about metacarpo-phalangeal joints. Locomotion very limited—almost impossible; anæsthesia higher than the knee joint. Patient very despondent; anorexia. Treatment with chaulmoogra oil in the same manner as for Case I. The results are astonishingly good. The striking features attributable to the action of the remedial agent are: (1) the gradual but most positive absorption of the tuberculous deposit on the forehead, leaving, at this writing, scarcely any perceptible sign of same; (2) the slow but sure return of sensation to within a few inches of the wrist and ankle joints. The copper-colored pigmentation on the back and chest is fading. The vesicular rash has not yet put in an appearance. The absence of the vesicles at this date, I attribute to the fact that the patient had ceased taking the oil for some days before it became known to me, and consequently its alterative effect is not so far advanced as in the preceding case. Notwithstanding, the efficacy of the oil is amply manifested in the wonderful improvement brought about in this subject; swelling of feet is about all gone; only mild soreness is localized at the metacarpal phalangeal joint of big toe on plantar surface of right foot; locomotion is splendid. Patient complained in the beginning of continued cephalalgia, at times most intense; this form of neurosis has subsided entirely. His appetite has returned; his intellect is lucid; his movements are swift, denoting easy action of muscles, free mobility of joints, and suppleness of skin. Patient's countenance is also rapidly re-



suming a normal appearance, leaving no permanent traces of former disease.

CASE III.—Mr. G., aged about forty years, native and resident of one of our country parishes. Ran a frame, sash and shingle factory. Developed the disease about ten years ago. On admission to the hospital, patient's general health was very poor. Heart-beats rapid and weak, respiration short, complete loss of appetite. The voice very husky, at times he would be taken with nervous phenomena, laryngismus stridulus, a flushed feeling, vertigo, palpitation, cold sweats. Feet, on admission, were about the size of a small watermelon.

The usual signs of inflammation, heat, pain, swelling, were present; besides numerous ulcers, from toes to midway up the tibiæ, added fuel to the fire. Hands in fair condition, with the exception of beginning ulceration on the site of a few finger nails which had been exfoliated. Anæsthesia of all four limbs.

Hands and arms of a light tan color. Body and legs offered large copper-colored spots to inspection. Facial appearance characteristic of the typical leper; large tubercles with deep furrows between them, the integument of cheeks thickened and wrinkled; outlines of cutaneous folds irregular.

Nose sunken from necrosis of septum. Hyperplasia of skin covering the alæ of the nose; auricles of ears enlarged, particularly lobules. Very scant supply of eyebrows; a few hairs on upper lip and on chin. Mr. G. says that at one time he had no cause to feel ashamed of his eyebrows, moustache or imperial.

When treatment was begun with the oleaginous agent our man was very skeptical about the benefits to be derived from its curative principle, and reluctantly submitted to my instructions. He positively believed the death-knell had rung for him, and my endeavors in his behalf would be fruitless. To submit to the imbibition of the greasy looking medicament, it required on his part extra resolution. His plea to dispense with same was only met by me with more forcible language in praise of the medicine, so thoroughly convinced am I of the value of the medication from recent literature on the subject. He has undergone the ordeal with happy and surprising results to both himself and his doctor. The face as a whole has greatly diminished in size. The tubercles have dwindled

wonderfully, the absorption beginning at the periphery and advancing toward the centre. The furrows in consequence are very shallow—skin over cheek, nose, etc., does not offer the same excessive growth as before treatment; patient's voice much clearer; he is free from all the nervous phenomena mentioned above. Pulse good; respiration normal; appetite splendid.

The peculiar vesicular rash, which was mentioned as one of the developments during the treatment of case I, is also to be seen in this patient, making its appearance only a few days later. Pruritis is present also. No itching prior to this. At my last visit on Tuesday, desiccation and desquamation had begun where the eruption first appeared. Fading of the spots has been going on for a little while back, and I detected in some places a tendency to splitting, as alluded to in the case of Mr. W. The skin is recovering rapidly some of its former pliancy. Hands are well; no ulcers; free mobility of fingers, wrist and arm; whereas before, great or swift movements would produce pain.

Besides the absorption of the tubercles and the thickened folds of skin on the face, by which process our subject is fast losing the characteristic leonine facies, to the efficacy of this medicine for leprosy I attribute the almost astounding cure of the diseased feet, within a month from beginning of treatment. When the patient is in a prone position, or when his feet are at rest in an elevated position, there is no œdema and the feet are of a natural size. Walking, or resting the feet upon the floor for hours whilst playing at cards with his fellow-inmates, causes some swelling of the pedal extremities, which quickly leaves on lying down.

Every ulcer has long been healed, leaving scars as silent monitors of their former seat of mischief. I forgot to say that on admission to the institution, his feet had every appearance of threatening mortification. This man is highly elated over his present condition, and never tires of praising the oil.

The remedial properties of the oil externally have not been fully tested; therefore, I refrain, at present, from speaking much about this matter. However, I have seen a few abrasions of skin and one small superficial ulcer heal very rapidly by applying the oil with a feather several times daily.

From my experience with chaulmoogra oil, I have come to the conclusion that in it, we have a most powerful alternative to a certainty, and *perhaps* the only reliable remedy for leprosy.

Since I wrote the account of case I, I paid him a visit, and found him in a state of excessive hyperhidrosis. This man has had some sweating all along, but nothing to be compared with his condition when seen last. This hyperhidrosis was not observed in either of the other cases.

This oil deserves the appellation of "specific" in the treatment of this loathsome disease. Its absorptive properties are incontestable and sufficiently shown in the decrease in size of the tubercles, thickened folds of skin, and the rapid fading of the discolored portions of the body. It affords immediate arrest of all nervous phenomena. Ulceration stops at once under its use, and probably mortification and necrosis are prevented, if not too far advanced. A return to better health, and a contented state of the mind further attest the efficacy of this agent.

Dr. Beaven Rake (*Annual of the Universal Medical Sciences*, issue of 1891) finds that patients believe in the value of chaulmoogra oil, and that they frequently beg for it. Experiments upon eighteen patients show increase of perspiration, decrease of tubercles, improved appetite, and a sense of well-being, increase of sensation, and increased suppleness of skin, and lessening of pain in the joints. The oil was not administered in capsules, but drunk pure. The dose used appears to have been about half a drachm to a drachm daily. With me the dosage began with ten drops three times daily, taken in a spoonful of water, after meals, and the dose increased gradually until the patients are now taking forty-five drops three times daily. It is my intention to reach sixty drops at a dose, unless I should discover some cumulative effects with untoward effects.



## THE INUTILITY OF CAUTERIZING VENEREAL SORES.

BY DR. JAMES M. GASSOWAY, M. H. S.

The misery of the unfortunate possessor of a chancre, be it hard or soft, is certainly sufficient to excuse him from any further torture in that line; yet, with singular unanimity, syphilographers still persist in urging the claims of a procedure, which if not obsolete, is unhappily very painful. Writers on venereal diseases have in this latter day descended somewhat from the high ground taken by themselves in the matter, as illustrated by the latest edition of Van Buren and Keyes—who may, not inappropriately, be taken as the type. No one of them positively advocates the claim that cauterization will, however early applied, cure or even favorably modify a hard chancre. In the article of the writers cited, this statement appears: "What more striking evidence could there be of the inability of any local cauterization to interfere with the regular development of this blood disease, after it has been once acquired, than the reports of Clerc's medical student, who washed himself, and of Hill's case of the man who tore his frænum at 4 A. M., was freely cauterized by fuming nitric acid; yet each case was followed by the regular manifestations of true syphilis at the usual interval." While thus practically abandoning cauterization as heretofore practised in hard or true chancre, after some further discussion, they exclaim, "How different with chancroid! It can be aborted by applying certain fluids to the inoculated spot within a few hours, and it can be destroyed totally by caustic after it has appeared." So far—good! A few pages previously in their article, "Treatment of Chancroid," the opening sentence speaks thus: "As a rule, chancroid does not come under the surgeon's notice until it is already advancing and beyond the reach of any abortive measures other than actual destruction by caustics;" and shortly thereafter, goes on to say, "once present, no treatment yields as satisfactory results as the entire destruction by an efficient escharotic, thus artificially imitating nature." A few applications are then mentioned, fuming nitric acid, sulphuric acid, the red-hot iron—and the article continues dogmatically: "Hence, the rule: If cauterization be decided upon, burn *every portion of every ulcer*, no matter what size;" thus in one

and the same sentence, as judged by the context, laying down an inalterable rule, and yet fatally modifying it. From these quotations, which will, I think, be found substantially the consensus of articles on this subject, it will be seen that while the cauterization of the hard, true chancre is suggested as at least a valuable experiment, the cauterization of the soft sore is a *sine qua non!* or, at least, of so great an utility, that it may be considered, indeed, almost a specific.

A few pages further on the treatment is modified. Iodoform, locally, is brought forward as superior to anything short of cauterization for those recalcitrants who decline to be burned alive, and for that further class of incorrigibles who refuse to advertise their disabilities by perfuming themselves with this product. "A simple application of a little dry, scraped lint, often renewed, is a fair treatment." I quote this last literally. The positive insistence of page *a* for cauterization, gradually gives way to iodoform locally on page *b*, and both gracefully yield at page *c* to a "little dry, scraped lint."

Some years ago I had charge of the venereal ward of one of the largest marine hospitals on the Atlantic coast. The number of venereal cases, while by no means so large as commonly supposed, yet were sufficiently numerous to occupy much time and considerable attention. The sores presented were of all ages, and, I believe, of every possible size. Cocaine had not then come into general use; indeed, it was practically unknown; and local anesthesia by rhigoline, benzole and ether sprays was as disappointing, practically speaking, in those days as in this. More so, perhaps. From want of time, ether or chloroform inhalation was out of the question, and I confess that I accidentally discovered that cases kept scrupulously clean, and saturated with a lead and opium wash, got well quite as quickly, and with much less pain to the patient, or trouble to myself, than if anointed with the time-honored nitric acid, pernitrate of mercury, or Ricord paste. From intimate connection with a respectable number, probably not less than five thousand, venereal ulcers in the marine hospital service, and through the courtesy of medical friends at the civil hospitals of the large cities where I have been stationed, I am impressed with the belief, from the small number

of cases compared with the relatively enormous number of exposures, that the "system" of the person susceptible to the inoculation is deficient in some (probably as yet unknown) factor, temporarily or otherwise, and that this deficiency is to be supplied by the alterative and corroborant group of remedies; that the cauterization of these sores in the vast majority of cases is as unnecessary as it is painful, and that the use of opium locally, and, in many cases, internally, is by far the more cleanly, agreeable, and above all, effectual method of dealing with the local manifestation.

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## Hospital Reports and Clinical Notes.



### MALARIAL HÆMATURIA.

*Editor New Orleans Medical and Surgical Journal—*

DEAR SIR: I was much pleased to see the article of Dr. Bruce M'Vey in the August number of the JOURNAL. I have been interested in this subject, especially of late, and have been in search of literature on this disease. I remember reading an exhaustive article a year or so ago in the JOURNAL, but, so far, have been unable to find it. I wish to make some remarks upon a severe case which I have lately treated successfully; but before doing so, let me state that I have had no very extended experience with this disease, and have no new treatment to suggest. I have practiced in this locality five years, during which time I have met with some twelve or fourteen cases. In all of these cases the disease occurred in subjects who were more or less suffering from chronic malarial poisoning. All of the cases treated with heroic doses of quinine (20 to 40 grains) have ended fatally. I wish to call special attention to this fact.

When jaundice set in to an extreme degree, and there was delirium, death followed. When large quantities of thick, brownish-black urine was voided the cases ended fatally, with the exception of the last one. In none of these cases was there any expectoration of blood. The jaundice occurred on



the second or third day. One of the cases was of a remittent type, the bloody urine being passed only during the exacerbations of fever, and death took place after the third exacerbation, in spite of the large doses of quinine, gallic acid, ergot, digitalis and iron, that I had poured into him.

Now to the case in question. On August 30, 1891, I was called to see Mrs. M., aged 55. I found that she had had repeated attacks of malarial fever during the last two months, but had been able to move around till the day of my visit, when she was attacked with high fever, and voided a quantity of bloody urine. I prescribed powders of calomel and soda, 4 grs. each, to be given every four hours; 6 grs. quinine every three hours, until cinchonism should be well marked, and twice daily thereafter. Also fluid extracts of digitalis and ergot.

August 31.—Fever 103; urine almost black, thick and muddy. Jaundice setting in. One slight action of the bowels. Great restlessness. Nausea and vomiting. To guard the stomach, I discontinued the ergot  $\mathcal{R}$ . Gave her about 15 grs. of calomel immediately. Ordered the calomel and soda continued, and having seen favorable mention made of large doses of arsenic, in *The Annual of Universal Medical Sciences*, I substituted the following for the ergot and digitalis  $\mathcal{R}$ , which had disagreed with the stomach.

$\mathcal{R}$ Ferri sulph. exs.....	gr. x.
Acid. arsen.....	gr. i.
Ext. digitalis .....	gr. iv.
Ergotin (Bonjean's).....	℥ ii.
$\mathcal{M}$ —Ft. pill No. xx	
Sig.—One every four hours, night and day.	

This  $\mathcal{R}$ , together with the calomel and quinine, was given with the utmost regularity. I discarded the gallic acid, as it checked the bowels.

September 1.—Temperature, 101; jaundice well marked, the conjunctivæ being yellow, and the whole body decidedly jaundiced. Urine worse, if possible, but much less in quantity, not over a pint in twelve hours. Bowels just beginning to act freely. Great restlessness, but no delirium. Patient states that she has not slept a moment. Nausea and vomiting, but not to such an extent as seriously to interfere with medication. Continued treatment.

September 2—No fever. Great restlessness. No sleep. Jaundice more marked. Little or no change in urine and other symptoms. Made no change in treatment.

September 3.—No change except that during the night there had been one voiding of urine much improved in color, though the very next sample was as bad as ever. As there was very marked cinchonism I ordered only one capsule (6 gr.) daily. Discontinued calomel, as bowels were very loose. As I

was getting into my pirogue to return home, the old man came shouting down to the bayou with the *pot* in his hand, which now contained about one pint of almost natural urine. You may imagine the delight with which we viewed the contents of this humble vessel.

The patient steadily improved, in spite of the *salivation*, which was quite severe. I had risked that, in view of the gravity of the case, and had warned the family. She took in all  $1\frac{1}{4}$  grains of arsenic, which puffed up her face almost beyond recognition.

And now, by way of summary, we see the irregularity of symptoms mentioned by Dr. M'Vey, and also, that in different localities we have different sets of symptoms, which are characteristic of the special locality. This has a great bearing on the case in question, for in this locality (eighty miles west of New Orleans and near the sea marshes) the disease is always almost fatal, and especially so when attended with such symptoms as we have seen in the case of Mrs. M., which gives additional strength to the supposition that she was cured by the treatment. I have heard of infallible cures, and know that many cases recover in some localities, but when I next meet the pithon of these swamps, calomel shall be my weapon, together with arsenic, digitalis, iron and ergotin, if occasion require.

GEO. W. DOUGLAS, M. D.

*Morgan City, La.*

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#### EYE, EAR, NOSE AND THROAT HOSPITAL.

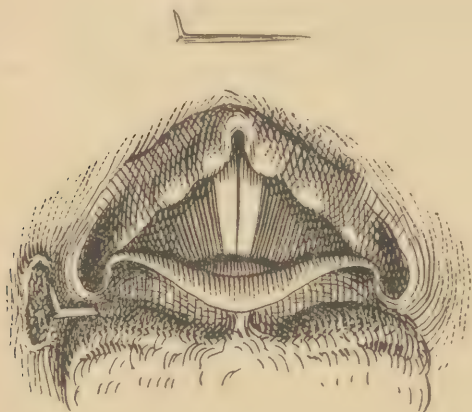
##### FISH-BONE EMBEDDED IN BASE OF TONGUE.

BY AUGUSTUS McSHANE, M. D.

On August 15, 1891, Louis White, negro, age 38, applied at the clinic for relief from a very distressing dysphagia. He stated that he had swallowed a fish-bone fourteen days previously. Swallowing became continually more painful, and he applied to a physician for relief; but the doctor did not see any foreign body in his throat, and sent him away without relieving him. Another medical man passed a brush (or ramoneur) down into his œsophagus, but it brought nothing with it.

When he applied at the clinic, he had not eaten for two days; he could only swallow a few mouthfuls of water on account of extreme pain. His throat was very irritable and painful; cocaine was swabbed liberally, giving him some relief. With the laryngoscopic mirror, a round, elevated, ulcerated patch was first seen on the right wall of the pharynx; touching with a

probe caused great pain. The patient before had referred his pain to a place above the roof of the mouth, but the probing showed where the pain came from.



The ulcer was cocainized. At the same time, a mass of muco-pus was seen lying on the base of the tongue, in front of the epiglottis and partly concealed by it. As the locality was very painful, cocain on a soft wad of cotton was applied. This application cleared away the muco-pus, and enabled me to make a longer and more careful laryngoscopic examination. When the tongue was pulled well forward, a small white substance was seen projecting from the base of the tongue, and scraping against the side of the pharynx, giving rise to the large painful ulcer. The foreign body was not always visible, since the epiglottis was close to the tongue and overlapped it partly.

The locality was thoroughly cocainized, and the foreign body removed with Frankel's forceps with a moderate amount of pain. The body was a fish-bone, one end of which grated against the pharynx, and caused such great distress. The patient felt relieved immediately after the removal of the fish-bone.

The position of the bone is well shown in the accompanying drawing, for which I am indebted to Dr. Quitman Kohnke.

The fish-bone is shown in natural size above.



## Proceedings of Societies.

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### BOARD OF HEALTH OF ALEXANDRIA, LA.

A Board of Health was created on June 1, the members consisting of the town councilmen and mayor, with Dr. R. L. Randolph as president of the board. Proper ordinances regulating the sanitary condition of the town were adopted; all physicians and midwives were required to register at the Health Office; and a record of all births and deaths occurring in the town are made in a book used for that purpose. It was made obligatory that all physicians report *instantly* all cases of contagious or infectious diseases occurring in their practice. This is the first effort in this direction made to establish a permanent record of births, and a record of the deaths occurring here, and the causes thereof.

RAPIDES.

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### ADAMS COUNTY MEDICAL SOCIETY, NATCHEZ MISS.

Pursuant to a call by the president, the Adams County Medical Society met September 1, 1891, for reorganization at the offices of Dr. N. L. Guice. The following gentlemen were present: Dr. W. A. McPheeters, Dr. N. L. Guice, Dr. L. H. Lamkin, Dr. A. J. Hall, and Dr. P. Beekman.

It was decided that the regular meetings of the Association should be held on the first Tuesday of each month, at which papers will be read and subjects of special interest to the profession be discussed.

Dr. P. Beekman was appointed essayist for the October meeting, and Dr. A. J. Hall essayist for the November meeting.

The following officers were elected for the ensuing year: Dr. N. L. Guice, president; Dr. W. A. McPheeters, vice-president; Dr. P. Beekman, secretary.

After a pleasant informal discussion the meeting adjourned.

PHILIP BEEKMAN, M. D., *Secretary*.

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### ALLEGHENY COUNTY MEDICAL SOCIETY MEETING OF AUGUST 18, 1891.

#### SUPRAPUBIC CYSTOTOMY.

By R. W. STEWART, M. D., Pittsburg, Pa.

The following cases operated on by myself during the present year, and given in the order of their occurrence, will serve to show some of the conditions for which this operation is in-

dicated, and also serve as a basis for further remarks on the operation.

Case I. This patient was under the care of Dr. Grube, who has kindly furnished me with the following notes of the case: February 10th, 1891. J. O., age 32, furnaceman. Patient says that about six months ago he first noticed difficulty in urination, with pain in bladder and penis. This gradually passed into chronic cystitis, accompanied by pain in legs and partial paraplegia. He was treated for cystitis at Mercy Hospital. The bladder is extremely irritable, and holds scarcely an ounce, and as the slightest distension causes intense pain, it is impossible for him to sleep longer than half-an-hour at a time; consequently he is greatly reduced in strength. The stomach is irritable, and digestion impaired; patient living almost entirely on milk. The prostate gland is slightly enlarged, and is nodular, leading to the suspicion that it is tubercular. Patient has a brother, who has pulmonary tuberculosis, and he himself has had a cough for several years, though his lungs are not perceptibly tubercular. Urine contains large quantities of muco-pus. Microscope shows pus cells, caseous flakes and debris. As patient was under Dr. Stewart's care at Mercy Hospital, I have asked him to see patient, and we have decided on suprapubic cystotomy.

February 14. Dr. Stewart operated as above, assisted by Drs. Ward, Patterson, Emmerling, and myself. As the bladder would not bear distention by fluid, the funnels was pushed up into wound by point of sound. A papillomatous growth was removed from near entrance of left ureter—about a teaspoonful of scrapings in all. Wound closed and bladder drained by single large drainage tube; directed daily washing out of bladder with boro-salicylic acid solution.

February 20. Patient has been given great relief from irritability of bladder, and is grateful accordingly. Urine still muco-purulent; general condition, bad.

March 10. Wound has healed nicely around drainage tube, and patient manages drainage and washing out of his bladder himself.

April 1. No improvement in character of urine, and patient losing ground steadily. There are occasional discharges of caseous-looking pus from urethra, which evidently comes from the prostate. Tubercles have made their appearance in the cicatricial tissue about the drainage tube.

The further progress of this case was a gradual decline, until he died about the middle of May.

Case II. Daniel R., age 54. About eight years ago he had several attacks apparently of renal colic, occurring at in-

tervals of two months. After this there was a period of quiescence until about eighteen months ago, when he complained of frequency in passing water, the termination of the act being associated with pain, which was referred to the end of the penis. Exertion of any sort aggravated the trouble, while on the contrary, rest in the recumbent position diminished it. So frequent had become the calls to urinate, and so difficult to restrain the desire, that it was necessary to wear a urinal. For about a year the patient was unable to pursue his vocation of machinist. He was referred to me for treatment by Dr. Ward.

Owing to the extreme sensitiveness of the patient, and the irritability of the bladder, an examination without the aid of an anæsthetic was a matter of considerable difficulty, and required the utmost tact and delicacy. A diagnosis of vesical calculus was made, and the patient sent to Mercy Hospital for operation. Accordingly, on March 15, the patient being anæsthetized, a rectal bag was inserted and distended with eight ounces of water. The suprapubic operation was then performed, and three calculi lying side by side were removed. A drainage tube was inserted in the bladder and the wound partially closed with three silver sutures. A loose gauze dressing was applied over all.

The condition of the patient after operation was satisfactory, and was devoid of constitutional disturbance. He left the hospital on the seventeenth day following the operation. A fistulous opening still communicated with the bladder, which was somewhat slow in healing, but eventually it closed, and at this date patient is in good health, has full control of his urine and is free from pain.

**CASE III.** Louis M., age thirty-four, a butcher by occupation. On the evening of May 28th, he stepped on a coal-hole, the lid of which turned and he fell, the edge of the lid striking him on the perineum. He was able to walk a short distance, and then took a carriage home. On the following morning he was suffering from retention of the urine, and Dr. Speer was called to see him. With a soft catheter he withdrew a quantity of bloody urine. On the evening of the same day I was called in consultation, the doctor being unable to withdraw his urine. At that time the bladder was distended, perineum tender, swollen and much discolored, the discoloration extending to the scrotum. A diagnosis of rupture of the urethra at the triangular ligament was made, and with the assistance of Drs. Speer, Christler and Mc Kibben, the patient being anæsthetized, I opened the perineum freely in several places, through which a small quantity of bloody urine escaped. A complete rupture of the urethra was



discovered. Owing to the extravasation, the tissues were so altered in appearance that it was impossible to distinguish the vesical end of the torn urethra, and after a patient attempt I abandoned the search for it, and ordered his removal to Mercy Hospital. He did not enter the hospital on the following day, and as he was still suffering from retention it was necessary to aspirate his bladder in the morning and evening. On the following morning he entered the hospital, and I operated on him again. At this time the patient's temperature was 103 deg. F., and his general condition was bad. Being again unable to find the vesical end of the urethra, I opened the distended bladder above the pubes, the incision in the bladder being just sufficient to admit a steel sound, with which I performed retrograde catheterism. The sound, after passing from within outwards through the prostatic urethra, was made to project through the perineal opening. While in this situation a stout rubber tube was fitted on the projecting conical extremity of the sound, which together with the tube was withdrawn into the bladder, and the sound disengaged from the tube. The sound was then passed from before backwards through the pendulous urethra, the extremity again presenting through the perineal opening. On this was fitted the end of the rubber tube which projected from the perineal opening, and the sound carrying with it the tube was withdrawn. By this manœuvre a tube was inserted in the whole length of the urethra, one end being in the bladder and the other projecting from the external meatus, the central portion bringing over the torn ends of the urethra, which were separated by an interval of about three-quarters of an inch. Displacement of the tube was prevented by pinning it to the prepuce. The patient's condition improved at once; his temperature was normal on the third day. The urine drained through the tube. A slight leakage escaped through suprapubic opening. On the eighth day the tube was removed, and the patient left the hospital on the twelfth day, since which time no urine has passed by suprapubic opening. A No. 26 French sound has been passed at intervals since that date. At present the sound is passed once every two weeks to prevent the formation of a stricture at site of injury, and except for this inconvenience the patient is as well as he ever was.

Case IV. A. M. W., age 21. Ten years ago this patient was suddenly attacked with a desire to urinate frequently, which he attributed to holding his urine too long. This condition has persisted without intermission during the past ten years, passing water every twenty to forty minutes, night and day, the act being associated with violent tenesmus, and, at times,

excruciating pain. The constant straining has produced a marked prolapse of the rectum, which protrudes during the act to the extent of about five inches.

Three years after the onset of this attack he became subject to epileptic seizures, which would occur about once a month, and in some manner seemed to be associated with an exacerbation of his vesical trouble. I may anticipate by saying that since the latter has been relieved the convulsions have ceased.

During the ten years he has suffered he has tried various forms of treatment in hospitals and out of them, under regulars and irregulars, besides his attempts at self-cure with the aid of patent medicines, all of which, to use his own language, did him no good, and he was waiting to die. Finally, Dr Buchanan sent him to Mercy Hospital, and he was transferred to me. The case was and is still something of a puzzle. The sound failed to shed any light on the subject. The cystoscope was also used, but nothing abnormal could be detected; external perineal urethrotomy was performed and a digital examination of the interior of the bladder was made by Dr. Buchanan and myself, but nothing abnormal, further than a dilatation of the opening of the right ureter could be detected. Into this opening I readily inserted the beak of Thompson's searcher, which passed without obstruction along the ureter until it must have reached the pelvis of the kidney. In this situation the searcher could be readily turned in any direction, showing that the ureter was much dilated. While the searcher was in this situation the descent of the liver in inspiration could be readily felt pressing against the extremities of the instrument. The ureter contained about an ounce of apparently healthy urine, which escaped along the hollow instrument. A drainage tube was inserted into the perineal opening, and the bladder drained by this means for ten days. During this period the patient had comparative comfort, and for the first time in ten years he was able to sleep a few hours at a time. After the tube was withdrawn on the tenth day, the perineal opening closed, and the patient relapsed into his previous miserable condition.

The results of these examinations showed that we were no nearer the solution of the cause of this trouble. Whether the dilated ureter was the cause, or the result of frequent urination, we were unable to determine; one thing, however, was apparent, that drainage of the bladder relieved the symptoms, and I, therefore, decided to establish permanent drainage.

In this operation I was again assisted by Dr. Buchanan. A specially contrived sound, having a greater curve than the ordinary sound, and a tip on it over which a tube could be

readily fitted, was used. The extremity of the instrument could be felt just above the pubes. An incision was made over it, and the instrument presented itself in the wound. A tube was inserted over the tip of the instrument, which was withdrawn, leaving the tube in the bladder, and a permanent drainage was now established. The patient, in a short time, was able to manage the tube himself, taking it out twice daily, and washing the bladder with a weak bi-chloride solution, the free extremity of the tube fitting into a urinal by day, and at night connected with a long tube which carries the urine to a vessel placed at the bedside. When last seen he had gained in flesh, could sleep without interruption, and, for the first time in his life, he was making arrangements to earn a living for himself.

The operation of suprapubic cystotomy has, within the past few years, attracted considerable attention, and is now looked on with more favor than at any previous period. Some have gone so far as to condemn entirely the perineal route to the bladder, and assert that the suprapubic route should be used exclusively; but that this is going too far will be evident to any one who will give the subject a little attention. For temporary drainage and for digital exploration, the perineal method of opening the bladder is undoubtedly the simplest and the safest. On the other hand, the suprapubic method is, in the majority of cases, to be preferred for the removal of calculi too large to be crushed; also for the removal of tumors, with the possible exception of prostatic growths, and for the establishment of permanent drainage. This operation has been hedged around with so many precautions and imaginary dangers that what is really a very simple operation appears to the uninitiated to be one of great magnitude.

Elaborate dissections have been made to show the relationship of the vesico-parietal peritoneal reflection to the operation, and the benefits of rectal and vesical distension has been urged. The dangers of urinary extravasation and hæmorrhage have been pointed out, and the advantages of Trendelenberg's position dilated upon. Regarding the much-talked-of peritoneum: In none of the cases that I have recorded was it seen during the operation, and in only one of them was a rectal bag used. While vesical distension was resorted to in none, though present as an accidental occurrence in Case III, the advantages of both of these have, in my opinion, been more than counter-balanced by the risks incurred from over-distension in their use. A longitudinal incision was used, keeping close to the upper border of the symphysis pubis, and the bladder opened on the tip of a well-curved sound, the finger being kept at the



same time in the upper border of the wound to prevent displacement downwards of the peritoneum and intestines. A pair of forceps was next insinuated alongside the sound, into the bladder, and expanded so as to tear the vesical opening to the extent desired. Hæmorrhage was not troublesome in any case. No attempt was made to suture the vesical wound, nor would I recommend that it be attempted, unless the opening was very large. In three of the cases the abdominal wound was partially closed with silver sutures; but in each of these the wound reopened on removal of the sutures, so that in the future I will dispense with their use. I would recommend, however, that the incision, both in the abdominal wall and bladder, be limited to the smallest extent consistent with the requirements for operating within the bladder.

No constitutional disturbance was produced by the operation in any case, no extravasation of urine occurred, and the after-treatment consisted of frequent renewal of the dressings and washing out of the bladder with a mild antiseptic solution.

#### DISCUSSION.

Dr. Buchanan—I am very well acquainted with the history of the fourth case reported by Dr. Stewart, and I think the doctor deserves the greatest credit for the way in which he followed up the treatment. The case was a very mysterious one, and yet remains so. There was no obstruction of the urethra. There was no active cystitis. There was no disease in the kidney, or in the pelvis of the kidney, as far as could be discovered. There was nothing to give rise to the dilatation of the ureter, the enlarged outlet of which could be felt very plainly with the finger through the perineal incision, and demonstrated with the sound, except the constant contraction of the bladder. The opening of the bladder for permanent drainage above the pubis was an entirely arbitrary matter, not based on anything except the fact that during the time at which the bladder was open below, the patient was relieved from pain. For this reason I think Dr. Stewart deserves the more credit for following up that hint, and doing this operation without any other indication; an operation which has certainly proved very successful. The man was in a wretched condition; the contractions of the bladder were so painful as to make him cry out; he could not stand still when passing his water, and there was very extensive protrusion of the rectum.

Dr. Macfarlane—I have nothing to say except to compliment the doctor upon the manner of presenting his cases. There is one feature about the one case in which I can not help but admire the manner in which he treated it. The case is the one

in which he had rupture of the urethra. Now anybody who has ever attempted to do anything with rupture of the urethra, knows the difficulty connected with it. I have on two occasions seen men of ample experience spend two hours or more before being able to unite the urethra; on another occasion an hour and a half was spent with lack of success, the work being left to be completed at a later time, the man being, in the interval, in a precarious condition. Now, the doctor's method of treating that, I think, deserves widespread circulation, for it certainly acted very well indeed, and affords a very happy escape from the great difficulty connected with a case of rupture of the urethra.

Dr. McKennan—I have a specimen which may be of interest to the members of the society. It was sent to me by Dr. Ray Grayson, of Washington, Pa. It is a congenital malformation of the rectum. The rectum ends at the base of the bladder. It is interesting on account of the fact that we very seldom get a *post-mortem* in cases of this kind, and it represents a type of cases not at all uncommon. An examination of the rectum here discloses the fact that there is peritoneum connecting the rectum with the bladder. The rectum enters directly at the base. Some times the rectum enters the bladder at the vertex. After an examination is made, it will be seen that the peritoneum surrounds the entire lower part of the rectum, running from the bladder directly to the rectum and surrounding it. This case represents one of a type of these cases of congenital malformation of the rectum which vary from occlusion of the anus to complete absence of the lower bowel. It is said that congenital malformations of the rectum and anus occur about once in every 5000 deliveries, although some observers state that in statistics of 66,000 cases of delivery, congenital malformation of the rectum and anus occurred only three times. Other observers, however, state that congenital malformations do occur as often as one in every 5000. To my knowledge, quite a number of cases have occurred around here. It is obvious from the malformation here that operative procedures were hazardous. An attempt in this case was made to reach the rectum, but failed. The diagnosis was properly made of entrance of the rectum into the bladder by the appearance of the fæces in the urine. The operation, I believe, was made on the patient on the seventeenth day, and the patient lived until the twenty-sixth day.

Dr. Stevenson—I have seen three cases of imperforate anus; in one of the cases the rectum terminated in the bladder. In that case there was an attempt made to reach the rectum, but it failed and the child died. In two other cases I have

seen, the rectum was reached, and the method pursued was passing up a hypodermic needle and withdrawing the faeces and cutting up alongside of the needle, and the rectum was reached and drawn down and the opening stitched. These children both recovered, and had no trouble with their bowels.

Dr. Stewart—It seems to me that in this case a suprapubic cystotomy would have been proper, and would have given relief.

Dr. Buchanan—I think a very much better way would have been to open the sigmoid flexure of the colon; that can always be reached. It would be very much better to drain the faeces out by an abdominal fistula than through the bladder.

Dr. McKennan—I find that operations in cases of this kind have never been successful. Operations have been done, some operators opening the perineum, cutting into the bladder and thence making a cut clear through the opening of the rectum into the bladder, making thus a large wound into the perineum. But this method of procedure either produces peritonitis or it causes a fistulous opening in the perineum, which greatly contracts. The only operation which can be done with safety is that suggested by Dr. Buchanan, that is the operation of colotomy. I find that in malformations of the anus and rectum, that in which the rectum enters the bladder occurs in about 40 per cent. of all malformations.

#### GENERAL DISCUSSION ON SURGICAL JOINTS.

Dr. Murdoch—I am not exactly clear as to what is meant by surgical joints. I suppose it may be joints liable to disease or injury, or that might come under the care of the surgeon, but in that case it would properly include every joint in the body, for there is no joint that might not require surgical treatment; therefore I do not like the term wholly. I suppose, however, reference is intended to be made to those joints which more frequently come under the care of the surgeon, either for disease or injury, and as that would be so much as to include the whole subject of tuberculosis and all kinds of injury to the joints, I am not able or willing, and if I were there would not be sufficient time, to discuss the subject as a whole. It might be said, however, that there have been great changes in the surgical treatment of joints within a comparatively few years, as you are all well aware. This has arisen in a great measure from the fact that because of the great improvements in surgery since the introduction of antiseptic treatment of wounds, the joint can be invaded and dealt with with so much less risk than formerly. That is one reason. And it seems to be a sufficient reason in the minds of a great many surgeons, that



simply because joints can be got into and incised or scraped out, that is a good reason for doing it, and of course this must enter into the problem of whether such an operation should be done.

Another reason why the joints are more frequently treated surgically now than formerly is owing to the changed views with regard to the chief disease which attacks the joint, namely, tuberculosis. Without entering into a discussion of the pathology of that disease, we are all, I believe, convinced that the former ideas with regard to it were not correct. I think we all believe now that it is an infectious disease, and is not always inherited from the parent. We believe the trouble is usually of local origin, and there is a local focus from which the disease starts, and it is in that view, I think, that a great many operations are now done by surgeons who would have formerly looked with doubt upon the idea that the local focus of the tubercle can be taken away before it has found localities in other parts of the body. In my recent visit to Europe, both in Ireland and Scotland I saw surgeons there opening into the joints in cases where I am sure nobody here in the United States would think of operating upon, nor do I believe they would be permitted to operate. I saw the joints of young people opened where there were none of the aggravated signs which we look for here, with a view of excising this local focus which it was believed existed either in the bone or in the joint. I saw, for instance, a surgeon, Dr. McEwen, of Glasgow, operate on a child about fourteen years old, able to walk without much limping, but afflicted with what we call the first stage of hip joint disease. I saw him cut into the joint and remove the head of the femur. In Ireland I saw a surgeon operating by what they call there an anterior procedure. In these operations they did it in the first stage of disease, before the disease had extended and made much or any destruction of the joints, but they do this operation on an entirely different principle from what I have been in the habit of seeing. They do it with the least possible violence to the joint; the head of the bone is not thrown out of its position.

In both of these operations Dr. McEwen did his operation posteriorly, making the usual incision from the crest of the ilium down from the joint, a short incision, and then introduced his chisel through an opening not over an inch and a half long, and by its manipulation, much pressure and lateral motion, he was able in a very short time to cut off the head of the bone, and then introduce his finger and extract the head. As I said before, I do not believe this would be permitted in our country. We see so little of joint diseases here, tubercular diseases, compared with what I saw in Ireland and Scotland.

This is accounted for by the fact that the patients are not so well fed there. Among the poor in Scotland, the number of young people with joint disease is remarkable. Now, as I said before, I do not expect to be able to treat all of this subject, and I must say that I have had very little experience in the treatment of any of the joints, excepting that of the knee. I have had some experience in that, and have excised the knee some eight times, I think, and with seven successful cases. My friend, Dr. King, at the West Penn Hospital, has perhaps excised more, and has lost but one patient. I wish to speak of the difference between present practice and that in vogue when I was a young surgeon. I know of no subject which shows the great improvements that have been made in surgery more than this one of the manner in which the joints can be opened. During our late war, for gunshot injuries of the knee joint there were fifty-seven operations performed, of these fifty-seven, forty-four patients died. Mr. Otis, in his report of our late war, states that previous to the war there were some eighteen excision of the knee joint, of which sixteen were fatal. Now, the operation of excision of the knee joint is one that is almost universally successful, that is, the patient seldom dies under the operation, and it usually results in a useful limb. In Ireland, where they do this operation a great many times, with success, I was shown at the Richmond Hospital some twelve cases that Dr. Thompson had in the hospital under recovery. He told me he had done the operation forty times, with only one death, so that no doubt the operation is one recognized as proper, when formerly amputation would have been in all these cases considered the proper course. When I look back upon my practice, even as late as when I became surgeon of the West Penn Hospital, within twenty years, I can remember patients who lay there for a year, or two years, with white swelling, as we called it, and eventually perished. I have seen some of these cases amputated, and I have seen several of them succumb simply from the confinement and the inability of the doctors to do them any good. Now these cases would not be permitted to stay there two weeks before some surgical operation would be performed for their relief. As you know, a local focus exists in tuberculous disease; it may be necessary to incise the joint, but in other cases, when only the synovial membrane is involved, the operation of arthrotomy may be performed; opening the joint up widely and dissecting out the entire synovial membrane and scooping out with a gouge any local focus that may be found. The disease, I do not believe ever commences in the cartilage. I desire, however, to state at this time, and it is probably all that is necessary for me to say to you to show the method that

Dr. Thompson uses to the knee joint, after having opened it, that this is much superior to anything I have seen, although it is a good deal like the apparatus which I use myself. I have brought it with me and I will show it to you.

In operating on a knee joint, they are in the habit of making what is called the horseshoe incision. This is made by commencing well back, and carrying the knife downwards and upwards across a corresponding point on the opposite side, the joint opened, and if it is only desired to perform arthrotomy, the whole of the membrane is scraped with a scoop and cut away with the scissors, and then the flap is replaced. But if, on the other hand, it is desired to perform excision of the joint, the bones are cut off and fastened together with nails and a splint. The design of those who operate by cutting parallel with the articular surface is to leave the limb at the same relative angle. Dr. Thompson and those surgeons who have had the most experience in operating, tell me that is not the proper way to make the section of the femur; he makes the section of the femur at right angles with its axis, so as to make the leg perfectly straight, as it is in the normal leg. I am inclined to believe that is the better way. I will not go into the manner of cutting the bone, as the surgeons all know that as well as I do. The best way of fixing the limb, that is the important part of the operation. I presume part of the success of this operation in recent years has been owing to this fact. Older surgeons have been in the habit of using wire and other appliances, which did not accomplish the purpose very well. I believe the idea of doing anything to keep the parts in apposition originated in Germany, by the use of steel nails driven with a mallet into the bones. I do not think that was as good a means for keeping the bones in place as the one suggested by me. In Ireland they use silver pegs about an inch and a half long, after making a hole with a bradawl. The nails which I use are four and a half inches long for an adult. They are made for me by Mr. Helmold, and according to the pattern of Mr. Wyeth. The nail should be tapered so that it binds as it proceeds. Three nails should be used. They hold the bones in perfect apposition with the assistance of the external apparatus.

The apparatus which Dr. Thompson uses, and which I think is the best way to hold the limb steady, is made from common hoop iron, an inch and a half wide. This is easily manipulated; it is simply wrapped around with a bandage over it to hold it in place, an anterior and posterior splint. The posterior splint is put down around the ankle joint and up on the foot, the anterior one leaving a space for the dressing over



the knee joint, and after the operation it is not disturbed for three weeks, unless the elevation of temperature is over 100 deg. F. There is a drainage tube put in across the joint behind the bone, well down, and usually it is a very successful operation. I could relate some of my cases, but I will not trouble you with that; the time is passing. I will, however, mention a case that I operated upon at the West Penn Hospital, a man 47 yers old, a miner, suffering with disease of the joint. Although in his case I feared the operation could not be very successful, the man made a remarkable recovery. He walked into the operating room four weeks after the operation with a cane, and left the hospital in eight weeks. He had been suffering for two or three years. I received a letter from him three months after he left the hospital. He said: "With the greatest pleasure I let you know that I am walking without crutch or cane. It was on the 5th of February that I walked. I was very much surprised at myself when I did it. From the day that you operated on my knee until the day that I walked was four months and eighteen days. How is that for an old man? Therefore, I thank you most respectfully for your skillful operation on me."

The joints in which operations are the most useful, and in which the surgeons now have the most experience, and have done the most benefit are the knee, the hip and the elbow. Excision of the elbow for injury is a most successful operation; so is excision of the knee. But I will say, as I said in the beginning, that there are many surgeons who think that because excision of the joint is done with such safety there is a good reason for doing it. It should always be remembered, especially by the young surgeon, that an excised joint is an admission on the part of the surgeon that he is not able to cure it. As our knowledge of tuberculosis advances, and we are able to treat tuberculosis successfully in the lung, we will be able to treat it successfully in the joint, and operative interference will not probably be essential then. It should never be forgotten, as the very first principle in the treatment of all joints, that the first consideration is rest, putting the parts at rest. If joints can be kept still even where there is a local focus of tuberculosis, if they can be kept still, and proper hygienic measures resorted to, many cases will never call for aid from the surgeon. I believe the improvement of the treatment of disease rests in an early diagnosis and early treatment. Having said this much with little regard for order, I leave the matter in your hands.

Dr. Davis—The term surgical joints has been used to describe joints that call for surgical interference.

Dr. Stevenson—I have never made claims to being a surgeon,

but have been so situated that I have had to do a little surgical work. I practiced for twelve years in Westmoreland county; I was medical man, surgical man, obstetrical man, and so forth. I had charge at that time of the Penn Gas Coal Company's works, which employed some seven hundred men, and I necessarily saw a great deal of injury. I think the first case I saw after I opened the office was a compound fracture of the ankle joint, with dislocation of the tibia. After cutting, and having two or three men exert all the strength they could, I could not get the tibia returned into the joint, so I found a meat saw and sliced off about half an inch, and got it reduced, and that man is walking about to-day. I saw not long after that a carpenter doing something with a foot adze, the corner of the adze striking him just over the joint, and penetrating the joint. When I saw him the synovial fluid was exuding. This being before the era of the antiseptics, it ended in an amputation about four inches above the knee joint. The man got well with the loss of the limb. I have no doubt the improved methods of treatment would have saved that man's leg. I saw another case which was probably a tuberculous joint. It seemed to start without any known cause, and after continuing quite a number of months the joint suppurated, and I found it necessary to amputate above the knee. That man was not so fortunate as the other; his general health gave way, and he died, although the stump had healed and done fairly well. One of the first important things is the diagnosis. What have we? Now, in joints we have a great many structures, there is bone, there is a cartilage, there is synovial membrane and ligaments, and the surroundings. Any or all of these may be involved, or none of them may be. We have what is called simulated disease in joints, the same as we have simulated diseases of other organs. We may have a mimicry of disease in a joint, and this may simulate almost anything. It is a very important matter when a surgeon or practitioner is called to a lady, nervous, of inherited tendencies, want of stability, easily excited mentally, and finds that she is complaining of severe pain in her knee. You look at the joint, you see it is swelled; she says she can not use it, you attempt to use it, she screams out with pain. No doubt it is very important to determine whether it is a hysterical joint.

The constitutional history of the patient may decide this, but if you have an inflammation of the knee joint, you will have local heat. Possibly, you will have constitutional heat. If you feel this joint and it is cool or clammy, and you take the temperature of the patient, and you find there is no fever, there is strong ground for suspecting that you have no chronic trouble in the knee joint.

Dr. Batten—In speaking of operations for joint diseases I will not go into a discussion upon surgical treatment. I believe it has been established that these diseases are of a scrofulous nature, and it was believed that that was a fact up to the time that Koch discovered his bacilli. Since that it is believed that the tubercle bacilli caused all these conditions of the joint, and that they are not hereditary. There is a question in my mind whether they are not hereditary. I believe the bacilli can be carried from the mother, a phthisical mother or a scrofulous mother, to the infant. However, that is a question. But there is one case I know in which an operation was not performed. It was a boy about ten years old, whose parents were living. He had what was called white swelling or inflammation of the knee joint. He was placed under the care of a great many physicians or surgeons, but there was no operations performed, and he finally recovered from this condition, and is at the present time using all the joints and is an active, healthy man. I would say, however, that Dr. Murdoch is deserving of a great deal of credit for the manner in which he performs these operations, and the success that he has had in giving relief to the patients upon whom he operates.

Dr. Koenig—In surgery, I think we all admit, cleanliness ranks superior to godliness. In view of the recommendation that Dr. Murdoch has made of a certain instrument—the little household utensil with which he inserts his nails—it seems to me that we must accord him greater godliness than cleanliness. With his well known ingenuity he should be able to construct some appliance capable of being made aseptic, after which he would have no occasion to recommend the use of an instrument as crude as the one he has shown us.

Dr. Lange—I have recently seen a few surgical points. I will relate one or two cases. A boy about eight years old while playing on the carpet screamed, said he had hurt his knee, and when his mother got it uncovered, she found on the most prominent part of the knee a single drop of blood, which was wiped away, and the little fellow moved around the house, but limped. His mother instituted a search for needles and found half a needle with the thread in its eye. The accident did not seem to trouble the little fellow much until the third day. Although there was no swelling and very little heat, there was a good deal of pain, and when called, I considered it probable a piece of the needle was in the joint or about the joint, and that it would be the proper thing to anæsthetize the boy and attempt to remove it. This was done, a careful search was made for the piece of needle for more than an hour and a half. The joint, however, was not entered. After



that, the little fellow was put to bed and his limb on a straight wooden splint; he was kept in that way two weeks and then allowed to get up. He was up about a week and was again seized with pain and this time a distinct fullness of the joint. The four depressions at the four corners of the patella had disappeared and were replaced by four convexities which fluctuated.

The leg was put in plaster, and all motion of the knee joint was prohibited by the plaster for three months. Then the plaster was taken off and the boy beginning to be active, there was again a slight swelling of the joint, and the plaster was reapplied and kept on for a couple of months more, and then taken off; and finally we saw the end of that surgical joint. The needle has, in all likelihood, become encysted, and will likely do no more harm. The other case was that of a boy riding his velocipede and falling with it. He was picked up and carried home, and when his doctor saw him he concluded he had a dislocation of the femur, because the leg was fully an inch and a half or two inches longer than the other, and because it was rigid, immovable and painful. The doctor chloroformed him, and attempted to reduce the dislocation, and thought he had succeeded. He applied a bandage to the boy's thigh and pelvis, and put him to bed, and the boy complained very little for two or three days. After this the doctor took off his bandages, examined the limb, and found it was fully two inches longer than the other. It was then I saw the boy, and examined him under chloroform as the doctor had done. The curious part of the case was that when the boy was anæsthetized his limb was the same length as the other, and it was evidently not dislocated; but when the boy came from under the influence of the anæsthetic, the limb lengthened two inches. The parents sent for additional counsel, and the last medical gentleman called in concluded that the boy had hip joint disease. We could not make a diagnosis, allowed that to go, and put the boy to bed.

He was kept there two or three days, then got up and walked, and had no pain nor deformity. On a later occasion when I saw him he complained of pain, and again his leg was apparently two inches longer. We examined him very carefully, and we found that this was a stipulated disease, that, as my friend, Dr. Stevenson, has characterized it, it was a hysterical joint, and that the lengthening was not between the pelvis and the femur, but was produced by muscular tilting of the pelvis. The length from both anterior superior spinous processes, to corresponding points below, was always the same, even when the leg projected two inches beyond its fellow.

On the other hand, a line from an anterior superior spinous process to the other is not at right angles with the body, but two inches lower on the side where the leg seems longer. This boy is now actively about, painless and straight; but when he is cross, willful or disappointed, he complains of his hip, tilts his pelvis, and lengthens his leg.

Dr. Green—Dr. Lange's case reminds me of a surgical joint with which I have had some trouble. The patient, whom I have been called to see many times, has the power of dislocating the lower jaw. She is a girl of nine years; she has always been notorious for will power. Her mother told me that from childhood, whatever she asked for had to be given her. She would say: "If you don't give it to me I'll stretch," and immediately, were the request not granted, the child would begin to "stretch," and open her mouth just as wide as she possibly could, until her jaw would slip out. About two months ago I replaced the jaw; whether she has done much stretching since that time I do not know. I have known some persons who frequently had dislocations of the lower jaw, but in no other case have I seen a person who could wilfully, maliciously, bring about this condition of affairs by stretching, and this boy of whom Dr. Lange has spoken reminds me of the spoiled child who "stretches."

Dr. Buchanan—I understand the subject of the evening to be surgical joints, and those I presume, are joints which are subjects for surgical treatment, either from disease or accident injury. Vast improvements have been made in the treatment of injured joints within the last ten or fifteen years. It is within my recollection when a simple puncture of the ankle joint, and an injury requiring amputation of the anterior part of the foot, would have determined a Syme's operation, or an amputation of the leg. So great stress was laid upon the fact that *a joint had been opened*, and I believe this to be true with very many medical men to-day, that, when called to such a case, the question of amputation rises strongly in their minds. It is well known to-day by surgeons that the synovial membranes can be treated in very much the same way, and with the same impunity as the tendinous sheaths, or any other of the soft tissues of the body. The thing of importance is, when these cavities are open, to keep them aseptic. If this is done no harm can result from the opening, and in the case of the joints we have exactly the same means of keeping them aseptic as in the case of the peritoneal cavity, and we can, in addition, if desired, use antiseptic solutions.

Now, we are constantly called to dress injuries of joints, particularly fractures of the bones which go to form the

joints; and I am satisfied that the practice will be in the future, in many cases, to open joints, wash them out, repair the soft parts, and wire the fragments of bone where the joint has been subcutaneously opened, and where the bones can not be kept in apposition without great trouble, painfully pressing splints and firm bandaging. I am reminded of a case which Dr. Murdoch saw with me in consultation about a year ago. The patient had a simple fracture of the fibula and a fracture of the inner malleolus. I was called to the case and reduced the fracture without great difficulty, and was able to place the broken malleolus exactly in its position, and retain it there with a simple splint. Dr. Murdoch was called in consultation at the request of the patient, and to my satisfaction, the next day. We endeavored to replace this dressing by another more permanent in character. This set up a frightful spasm of the muscles of the fibular side of the limb, and the spasms were so great that, using all our force, we had not the power to overcome them and place the limb in shape. I never saw a patient suffer more than did this patient for a few minutes. These sharp-edged fragments threatened to break through the skin and form a compound fracture. I proposed at that time, although the patient refused to listen to any suggestion of the kind, to make an incision over the point of fracture, and put in a single silver wire to retain the inner malleolus in position, and the pressure of an ounce or two ounces on that silver wire would perfectly keep the bone in position. Having to start with a simple fracture, having made the wound ourselves, we could keep it aseptic; no harm could come to the joint.

I believe the time will come when that will be the ordinary treatment of such fractures in the neighborhood of joints, where the disposition to displacement is very great, where a very slight force exerted through a silver wire will hold the parts perfectly in apposition, and where we have every possible chance to keep the wound aseptic. There is another aspect of surgical joints not dealt with very often, and that is the advisability, where there is doubt, of making an exploratory opening. I see no reason in the world why exploratory openings should not be made into joints when we suspect disease, as well as into the peritoneal cavity, and as often; but such openings are, I believe, very rare. With regard to case reported this evening, of compound fracture of the inner malleolus and fibula, in which there was protrusion of the shaft of the tibia, in which the patient was etherized, and section of the tendo Achillis made, and a piece cut from the end of the tibia to facilitate reduction, I would say that I reported to this



society a year ago a case exactly similar in all respects. I did not find it necessary to do a tenotomy, and the bone was returned without sawing any of it off, and I can hardly imagine a case of this nature in which the same result could not be secured, providing the opening in the soft parts is sufficiently large to let the bones slip in. Muscular action is the only thing that would prevent the return of such a bone, and it can be completely abolished by anæsthetics.

Dr. Davis—All cases of joint diseases present certain characteristics peculiar to themselves, and require good judgment on the part of the surgeon at the time, and can scarcely be discussed in a general way, but there are joints that are difficult of diagnosis, that no doubt give rise to a great deal of distress to the patient, and give rise also to a good deal of distress to the attending physician, because of the long continued suffering involved. The youngest practitioner is likely to come in contact with such joints. One of the very important questions in such joints is when a surgical operation is advisable, or whether it is advisable at all. Take, for instance the tuberculous joints referred to. The question comes up, when to operate upon it. Will the opening of these joints remove the diseased tissue? Will it give the patient a better chance of life? It is but a few years since all cases of hip joint disease were considered the property of the surgeon. We have heard to-night of this being carried to extremes on the other side of the water, and operations done which would not be allowed here, and yet in looking at the statistics the operation on the hip joint has not been satisfactory.

In the first place, quite a large percentage of those operated upon have died; perhaps not directly following the operation, but within a few days or a few weeks after it. And of those who have recovered from the direct result of the operations, over one-half have died where the diseases have been of tuberculous origin, in such a short time that it is questionable whether the operation does not hurry the general disease. I have read somewhere that out of 388 cases of hip joint disease operated on, only 61 presented results that could be called satisfactory. Of these 61 there were about 40 that had motion in the joint. Of the 40 there were about 10 who did not have to use artificial means, such as cane or crutch, in walking. Results such as these are not flattering for the operation, and do not lead us to hurry or advise our patient to go into the hands of the surgeon, and submit to the operation, so liable not to be favorable in its outcome. And then in regard to operations on the knee. While we know that under asepsis it has improved wonderfully as regards immediate death, yet

the cases, especially where it is tuberculous, have not done as well as we could wish. And so of the ankle joint. I have in mind now a tuberculous ankle joint where operations have been advised over and over again. I do not know but that if this young man would submit to the operation, and have all this bone removed, the confinement in the house would hasten his end. It is difficult for me to know whether to advise an operation or not. The difficulty with the general practitioner is to know whether to turn such cases over to the surgeon, and with the surgeon to know whether operation ought to be resorted to.

Dr. Murdoch—I think the surgeons who are in advance in this matter of treatment of joints are tending toward diminution of operations at the late stage, where there is great injury to bone. Patients in that condition do not recover well from an excision of a joint, and I believe the tendency of the better surgeons nowadays, would be to recommend radical measures in joints such as Dr. Davis has described. If the bones are extensively diseased, and the joint extensively involved, the patient would be likely with an excision, to perish from a general giving away of the system. I fully believe that such surgeons as McEwen, of Glasgow, and Barker, of London, and the surgeons most in advance, operate early, when the disease is local, and before it has yet attacked the synovial membrane, then is the time to operate at the earliest stage, when it is possible to remove the disease, and it can then be removed through a smaller incision without disturbing the relations of the joints, and a movable articulation may then be possible. In Ireland and Scotland, where there are hundreds of these cases to one here, the people have been educated up to the necessity of not allowing this disease to go on, and are willing to submit to an early operation. I am very sure the people here will not submit to the early operation thought proper there. I believe that it will yet come to be the proper practice where a diagnosis can be made sufficiently early. I will say to Dr. Kœnig that if he will come up some time to my operations, I will show him how to do the operation, and how I have been so successful in preventing infection of the wound with the washouts I use.

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PRELIMINARY ANNOUNCEMENT OF THE PROGRAMME OF THE SEVENTEENTH ANNUAL SESSION OF THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION, TO BE HELD IN ST. LOUIS, OCTOBER 14, 15 AND 16, 1891.

I. "The Toxic Effect of Tobacco Vapor; with Report of Cases." W. Carroll Chapman, M. D., Louisville, Ky.

2. "The Management of Chronic Diseases." S. Baruch, M. D., New York, N. Y.
3. "The Ethics of Curing Consumption and other Chronic Diseases." John Ashburton Cutter, M. D., New York, N. Y.
4. "The Treatment of Typhoid Fever." Robert C. Kenner, M. D., Louisville, Ky.
5. "The Carbolates." William F. Waugh, M. D., Philadelphia, Pa.
6. "On Degenerative Processes in the Spinal Cord, Consequent upon Constitutional Diseases." Hugo Summa, M. D., St. Louis, Mo.
7. "Iliac Indigestion—Intestinal Dyspepsia—and its Treatment by Antiseptic Agents." Frank Woodbury, M. D., Philadelphia, Pa.
8. "The Influence of Graveyards on Public Health." S. W. Carhart, M. D., Lampasas, Texas.
9. "Rheumatism and Gout in their Casual Relation to Eczema; their Management." A. H. Ohman-Dumesnil, M. D., St. Louis, Mo.
10. "The Value of Epilation as a Dermato-Therapeutic Measure." Joseph Zeissler, M. D., Chicago, Ill.
11. "Gradation of Lenses." Dudley S. Reynolds, M. D., Louisville, Ky.
12. "The Influence of Alcohol on Vision." Francis Dowling, M. D., Cincinnati, O.
13. "Tobacco and Insanity." Ludwig Bremer, M. D., St. Louis, Mo.
14. "The present Aspect of Cerebral Surgery." Landon Carter Gray, M. D., New York, N. Y.
15. "Forensic Aspect of Bruises and Fractures in the Insane." J. G. Kiernan, M. D., Chicago, Ill.
16. "Amputation of the Scrotum, with Report of a Case." B. Merrill Ricketts, M. D., Cincinnati, O.
17. "Observation on Urethral Stricture." G. Frank Lydston, M. D., Chicago, Ill.
18. "The Mechanical Element in Treatment of Compound Fracture." Warran B. Outten, M. D., St. Louis, Mo.
19. "A Report of a Case of Retention of Urine caused by Multiple Urethral Calculi." J. V. Prewitt, M. D., West Point, Ky.
20. "Some Observations on Rectal Surgery in Europe." Leon Strauss, M. D., Louisville, Ky.
21. "A New Method of Diagnosing Obstruction in the Sigmoid Flexure." Jos. M. Mathews, M. D., Louisville, Ky.
22. "Pathology and Surgical Treatment of the so-called



Strumous Inguinal Lymphadenitis." L. T. Riesmeyere, M. D., St. Louis, Mo.

23. "The Treatment of Gonorrhœa." E. C. Underwood, M. D., Louisville, Ky.

24. "Extirpation of the Thyroid, with Report of Case." Emory Lanphear, M. D., Kansas City, Mo.

25. "Are Conservative Amputations always in the Interest of the Patient?" Charles Truax, Chicago, Ill.

26. "Sarcoma of the Dorso-Scapular Region—Operation—Recovery." George N. Lowe, M. D., Randall, Kansas.

27. "Mouth Breathing." Eric E. Sattler, M. D., Cincinnati, Ohio.

28. "Empyema of the Superior Maxillary Antrum, with only Nasal Symptoms." Hal Foster, M. D., Kansas City, Mo.

29. "A Superior Remedy for Nasal Catarrh; Campho-Menthol." Seth S. Bishop, M. D., Chicago, Ill.

30. "A Case of Reflex Aphonia; Demonstrated to be due to Pressure of the Middle Turbinate against the Septum Nasi." Hanau W. Loeb, M. D., St. Louis, Mo.

31. "Importance of Recognizing a Temporary Rachitic Condition in Infants." John A. Larabee, M. D., Louisville, Ky.

32. "A Pathological Study of Pelvic Inflammation in Women." Wm. Warren Potter, M. D., Buffalo, N. Y.

33. "Observation on the Management of Uterine Tumors." Chas. A. L. Reed, M. D., Cincinnati, Ohio.

34. "Complications Following Abdominal Section." Rufus B. Hall, M. D., Cincinnati, Ohio.

35. "Obstetric Dispensaries; their Management." L. A. Berger, M. D., Kansas City, Mo.

36. "Surgical Treatment of Peritonitis." A. V. L. Brokaw, M. D., St. Louis, Mo.

37. "Temperance No Guide in Peritonitis." H. C. Dalton, M. D., St. Louis, Mo.

38. "Some Monstrosities at and After Birth." David S. Booth, M. D., Belleville, Ill.

39. "Oophorectomy vs. Donothingism." Willis P. King, M. D., Kansas City, Mo.

40. "A Successful Gastrostomy for Impermeable Stricture of the Cardiac End of the Oesophagus—Subsequent Dilation of the Strictures." Arch. Dixon, M. D., Henderson, Ky.

41. "The Nervous Equation of Pelvic Inflammation." Geo. F. Hulbert, M. D., St. Louis, Mo.

42. "Hysterectomy for Cancer." J. M. Richmond, M. D., St. Joseph, Mo.

43. "The Application of the Obstetrical Forceps." John Bartlett, M. D., Chicago, Ill.

44. "Appendicitis." W. H. Link, M. D., Petersburg, Ind.
45. "Phthisis—Beginning its Treatment." Edward F. Wells, M. D., Chicago, Ill.
46. "The Hydrotherapy in Typhoid Fever." H. H. Middlekamp, M. D., Warrenton, Mo.
47. "Hystero-Epilepsy." Howell T. Perching, M. D., Denver, Col.
48. "Importance of Definite Strength in Mineral Waters." Geo. F. Hulbert, M. D., St. Louis, Mo.
49. "The Time and Place for Stimulants." By Chas. H. Hughes, M. D.

Regular classified programme will be issued and sent to members and the profession generally at an early date. Titles of papers must be sent to Chairman of Committee of Arrangements before October 5, 1891.

I. N. LOVE, M. D.,  
*Chairman Committee of Arrangements,*  
*Grand and Lindell avenues, St. Louis.*

E. S. MCKEE, M. D., *Secretary.*  
C. H. HUGHES, M. D., *President.*

#### FOURTEENTH ANNUAL MEETING OF THE AMERICAN SOCIETY OF MICROSCOPISTS NOW THE AMERICAN MICROSCOPICAL SOCIETY.

##### SPECIAL CIRCULAR.

From the fact of members of our society being residents in almost every State of the Union, it has always been the case that but a small proportion can make it convenient to attend any meeting—the remainder have only been able to learn what was done at any meeting, by waiting until the annual volume of proceedings was issued, usually six or more months afterward. In order that every member may know as soon as possible what was done at the late meeting in Washington City, it has been deemed advisable to publish the following statement:

The society convened according to announcement, on Tuesday, August 11, 1891, at 10 o'clock A. M., in the preparatory department of the Columbian University. After an opening prayer, by Rev. R. S. L. Wood, the address of welcome was delivered by Dr. J. S. Billings, F. R. M. S., of the Surgeon General's Office, U. S. A., followed by remarks by Dr. Thos. Taylor, President of the Washington Microscopical Society. These were responded to by President F. L. James, of St.

Louis, after which the society proceeded to the regular course of business, and so continued during the regular sessions until final adjournment on Friday afternoon, August 14. During the sessions the following papers were presented:

1. L. D. McIntosh—The portable lime light.
2. Prof. M. D. Ewell—A new form of graphological microscope.
3. Prof. M. D. Ewell—Standard glass and speculum metal centimeters.
4. Dr. James M. Flint—Apparatus for public and class exhibition of microscopic objects.
5. Wm. A. Rogers—The relations between a mikron and a wave length of sodium light.
6. Dr. J. Melvin Lamb—The microscope in government work.
7. Dr. Wm. C. Krauss—The microscope as a factor in the diagnosis, prognosis, and treatment of morbid new growths.
8. Dr. Veranus A. Moore—Apparatus for holding cover glasses when staining.
9. Dr. Veranus A. Moore—Observations on staining the flagellæ of motile bacteria.
10. Miss Vida A. Latham—A brief account of the microscopical anatomy of a case of chrome lead poisoning.
11. Miss V. A. Latham—The use of stains, especially with reference to their value for differential diagnosis.
12. Prof. Wm. H. Seaman—The phosphorescent organs of fire-flies.
13. Dr. Lucien Howe—Floating particles in the eye a source or error in microscopical observation.
14. Prof. Simon H. Gage—Notes on the fixation of serial sections, and the collodion method of histology.
15. Prof. Simon H. and Susannah P. Gage—Comparison of the epithelium of the mouth in *Necturus* and *Diemyctelus*.
16. Simon H. Gage—Preparation of the fibrin filaments of blood and lymph, and of the oxyhæmoglobin crystals of *Necturus*.
17. John Michels—The microscopical examination of pork by the United States government.
18. J. M. Stedman—On the nervous system of a fresh water sponge.
19. J. M. Stedman—The killing of Invertebrata in an expanded condition.
20. Dr. Lucien Howe—The mechanical stage used as a micrometer.
21. E. H. Griffith—New accessories made by additions to the Griffith Focus Indicator, etc.



22. Robert Moody—The arrangement of the muscular layers of the intestine of the cat at the junction of the large and small intestine.

23. Edward Bausch—A new microscope.

24. Dr. T. Taylor—A new revolving stage for exhibiting a large number of objects.

25. Dr. T. Taylor—An improved method of detecting lard adulterations.

26. Dr. Lyman Deck—A heliostat from a common clock works.

27. E. H. Griffith—Three new accessories for the microscope.

28. Henry L. Tolman—Hints on expert testimony.

The following persons were elected members: Dr. George N. Acker, Washington, D. C.; Dr. W. T. Baird, Dallas, Texas; Nathan Banks, Sea Cliff, N. Y.; Dr. James Barns-father, Cincinnati, O.; Prof. Thomas D. Biscoe, Marietta, O.; N. Howland Brown, Philadelphia, Pa.; J. C. Brubaker, Kansas City, Mo.; Prof. Edward A. Burt, Albany, N. Y.; Prof. S. W. Collett, Glidden, Iowa; Dr. Rand P. Crandall, Brooklyn, N. Y.; Chas. H. Dennison, Brooklyn, N. Y.; Prof. Arthur H. Elliott, New York City; Dr. James M. Flint, Washington, D. C.; Dr. Charles B. Gilbert, Washington, D. C.; Rev. Geo. Goetz, Erie, Pa.; Dr. Julius A. Gottlieb, New York City; Prof. Gustave Guttenberg, Pittsburgh, Pa.; Prof. Byron D. Halsted, New Brunswick, N. J.; Dr. Henry N. Heineman, New York City; Dr. Thomas Hood, Washington, D. C.; Dr. A. O. Ingalls, Murray, Idaho; Dr. Miles W. Ingalls, Lagrange, O.; Dr. H. L. E. Johnson, Washington, D. C.; Hebert E. Kenney, Littleton, N. H.; Dr. Joseph J. Kinyoun, Washington, D. C.; Dr. A. L. Kotz, Easton, Pa.; Dr. T. Melvin Lamb, Washington, D. C.; Prof. E. G. Love, New York City; Dr. T. W. Mecker, Nyack on Hudson, N. Y.; Dr. John Michels, Chicago, Ill.; Dr. W. S. Miller, Worcester, Mass.; Robert O. Moody, New Haven, Conn.; Dr. A. E. MacKay, Portland, Oregon; W. H. Ohler, Portland, Maine; Dr. Paul Paquin, Columbia, Mo.; F. Patrick, Topeka, Kansas; Magnus Pflaum, Pittsburg, Pa.; Dr. Otto E. Plath, Cincinnati, O.; Dr. Joseph P. Remington, Philadelphia, Pa.; Dr. Henry A. Robbins, Washington, D. C.; Dr. James Foster Scott, Washington, D. C.; Rudolph Siemon, Fort Wayne, Ind.; Dr. Chas. D. Smith, Portland, Maine; Prof. John B. Smith, New Brunswick, N. J.; Harry F. Startzman, Rochester, N. Y.; Dr. James Stimson, Watsonville, Cal.; Harry G. Wales, Philadelphia, Pa.; Dr. Geo. O. Welsh, Westborough, Mass.; Dr. Ernst Wende, Buffalo, N. Y.;

Jonathan White, Brockton, Mass. ; Dr. R. S. Willard, Buffalo N. Y. ; Frank Zentmayer, Philadelphia, Pa.

The annual address of the President, Dr. Frank L. James, of St. Louis, Mo., was delivered on Tuesday evening, August 11, at 8 o'clock, in the lecture room of the First Congregational Church, corner 10th and G streets.

Subject: "The Microscope in the Investigation of Scorches and Burns on Textile Fabrics," and was listened to with great attention by a large and appreciative audience.

During their stay, the members, by special invitation, visited the United States Geological Survey, on Tuesday afternoon ; the Agricultural Department, Bacteriological and Chemical Laboratory, on Wednesday afternoon ; the Army Medical Museum, and Fish Commission, on Thursday afternoon, and accepted an excursion to Mt. Vernon, for Saturday morning.

There was no working session as heretofore ; it being believed that an inspection and explanation of the microscopic work done in the various departments of the government would be more instructive, interesting and acceptable to our members.

On Thursday evening the usual public exhibition of Microscopes and objects took place in the Armory of the Light Battery and Cavalry Troop, attended by a large and interested concourse of people. About sixty-one microscopes were set up. In an adjoining room a lantern exhibition was given by Dr. L. A. McIntosh, and Mr. W. H. Walmsley.

For several years the question of incorporation of the society has been under serious consideration by some of the leading members ; this question was taken up at this meeting : and after discussion it was unanimously resolved to make application for a charter, and a committee was appointed for that purpose. This committee went immediately to work, and before the meeting finally adjourned had obtained a charter, under the law of the District of Columbia. The committee on revised constitution and by-laws reported, and were discharged ; a new committee was then appointed to make such changes as were necessary by the act of incorporation.

This committee reported a temporary constitution for this year, and the executive committee were empowered to prepare a new constitution and by-laws, and present at the next meeting.

It is confidently believed that incorporating the society will assure its permanence and greatly increase its usefulness. It has now a legal existence ; can own real and personal property, and defend its title thereto ; can become the donee and trustee of funds directed to be used in microscopical or other research, etc., etc., which it could not do heretofore.

It was also deemed advisable at this time to make a change in the name of the society—it is now, under the charter, entitled the “American Microscopical Society”—which it is hoped the members will find more appropriate than the original name.

It has often been cited as a reproach to American science that it contributed nothing in the way of *original research*. Our colleges and universities expend their energies in bringing young men up to the point where they are ready to begin this work, and with a few recent exceptions, offer no opportunity for them to prosecute it, when qualified.

Now the American Microscopical Society is organized for the express purpose of original research in a special field of science not covered by any other existing organization. It is composed of men who are actually engaged on the frontiers pushing their way into the boundless unknown territory of natural phenomena, and adding new areas to those we already own.

The Spencer-Tolles fund, now amounting to \$292, not yielding sufficient annual revenue yet to be used as a prize for original research as intended; two of our members, believing that a prize would stimulate some investigators and redound to the honor of the society, have placed \$50 at the disposal of the executive committee, to be given in two prizes, \$30 and \$20 respectively (in cash, or a medal of equal value), for the best two papers on subjects of original research presented at next meeting—the particulars and conditions of this feature will be announced shortly by the secretary.

The question of establishing a journal, controlled by, and published in the interests of the society, is one that has been discussed several times. Heretofore such discussions have not considered anything different in general character from the journals now published, but the fact that there are subscribed for or otherwise obtained by the government department in Washington *all* the scientific journals in the world, and that these journals are open to public use by any suitable person, renders it possible to publish a review or abstract of the microscopical literature of the *entire world*, here in Washington, without any expense for said journals. It is thought by some, that a monthly publication, consisting of abstracts of such articles as may properly come under the head of microscopical science, would be the greatest help to the advancement of and benefit to the society of anything that can now be done. The only obstacle in the way is the want of money to pay for the mere printing. The income of the society just about suffices for the publication of its annual volume of proceedings. It can not be expected in the light of experience, that such a journal



would at first pay its way, although this result is possible, after it should be fully established as a first-class reliable journal. To some members of the society, this seems to be the pressing need of American workers interested in the microscope. It has been suggested that the various colleges of the land should contribute a small sum each, and thereby secure for themselves a most valuable reference index, and the substance of the articles themselves. Also that, if possible, the object be presented to some of our wealthy men, as a mode by which they can greatly promote the advancement of scientific research in this country, by giving to the society a publication fund, to be invested and the interest used for this purpose. As the society is now incorporated, such a fund would be in responsible hands. It is believed that a corps of voluntary abstractors could be obtained that, for a time at least, would furnish the matter with little or no expense for the literary work. A committee was appointed to take the subject under consideration, and to report at the next meeting. Every member who can in any way assist in this matter, is requested to do so.

The report of the treasurer shows the society to be in satisfactory financial condition. At the opening of the meeting there was \$276.99 on hand, and all debts paid. It may be stated, however, that the society needs the dues of every member—money is required to carry on the work of the society, and the more that is available for the publication of the annual volume, the better the volume can be made—better for each member, and more to the credit of the society. The volume will be issued at the earliest possible date, also a circular announcing the particulars and place of the next meeting.

The officers elected for the ensuing year are: President, Prof. M. D. Ewell, of Chicago; vice-president, Dr. Robt. Reyburn, of Washington; vice-president, Dr. R. J. Nunn, of Savannah, Ga.; secretary, Dr. W. H. Seaman, of Washington; treasurer, C. C. Mellor, of Pittsburg, Pa.; executive committee, Dr. J. A. Miller, of Buffalo, N. Y.; Prof. E. W. Claypole, of Akron, O., and Dr. J. M. Lamb, of Washington, D. C.

Prof. S. H. Gage was also selected as chairman of the working session we hope to hold at the Columbian Exposition in 1893. It was felt necessary to begin in good season in order to make satisfactory arrangements.

Mr. E. H. Griffith was appointed chairman of committee on working session for 1892. Mr. Griffith has had so much experience in this department, and is so skilful and ingenious a worker himself, that his appointment assures that the work-

ing session will be a most attractive and useful feature of the next meeting.

It is hoped that all members will use their best endeavors to make the aims and purpose of the American Microscopical Society known to those of their friends or acquaintances who do or should take an interest in microscopical study or investigation, and to induce them to join. The dues are so small, and so much is to be gained by association in such a science, that we should have on our roll every one in the United States who uses a microscope. By a small effort on the part of each member, a large accession of new members can be made at the next meeting.

It is difficult for the secretary of the society to find out in our great country, the names of all those, so numerous, who are interested in the microscope, and who would be likely to become members of the society, if its character and work are made known to them. It is therefore particularly desired that every one who knows and is favorably disposed toward the society will make known to the secretary the name and address of any who may be induced to become members, so that the secretary can send them circulars, etc., published from time to time by the society, and that they may in this way become acquainted with it and be induced to join it.

Blank application for membership may be obtained by addressing the secretary, Dr. W. H. Seaman, 1424 11th Street, Washington, D. C. The admission fee is \$3, the annual dues \$2, payable in advance. This amount (\$5) may be forwarded with the application.

WM. H. SEAMAN, *Secretary.*

*Washington, D. C., September 1, 1891.*

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#### MISTAKES OF A PHYSICIAN.

First—To promise a patient that you will cure him.

Second—To promise to call at an exact specified time.

Third—To promise that the malady will not return.

Fourth—To promise that you can render more efficient service than your fellow practitioner.

Fifth—To promise that your pills are not bitter or that the knife will not hurt.

Sixth—To promise that the chill or fever will not rage so high to-morrow.

Seventh—To allow your patient to dictate methods of treatment or remedies.

Eight—To allow yourself to be agitated by the criticisms or praises of the patient's friends.

Ninth—To allow yourself to buoy the patient when the case is hopeless.

Tenth—To allow yourself to make a display of your instruments.

Eleventh—To allow yourself to experiment or exhibit your skill uncalled for.

Twelfth—To allow yourself by look or action in a consultation to show that you are displeased, and that if you had been called first matters would have been different.

Thirteenth—To allow yourself to indulge in intoxicating beverages.

Fourteenth—To allow yourself to rely wholly upon the subjective symptoms for your diagnosis.

Fifteenth—To allow yourself to tell the patient you are prescribing saccharum album when you are giving calomel.

Sixteenth—To allow yourself to give arsenic and quinine when a bread and water placebo will answer.

Seventeenth—To allow yourself to tell Mr. Smith the weak places and irregularities of habit in Mr. Jones' family.

Eighteenth—To allow yourself to give your services or an opinion without a reasonable fee or a reasonable expectancy.  
—*Kansas Med. Journal.—Practice.*

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#### AMYL NITRITE IN AFTER PAINS.

Winterburn uses this drug in severe attacks of after pains. He takes a small vial (two-drachm) and inserts a piece of paper, moistened with five or six drops of the nitrate. The vial is then corked and the patient directed to remove the stopper and inhale the drug when the pains assume a severe character.—*Archives of Gynecology.*



# N. O. Medical and Surgical Journal,

ESTABLISHED IN 1844.

PUBLISHED MONTHLY, \$2.00 A YEAR.

Articles from physicians are respectfully solicited. All articles, news and exchanges, and books for review, should be sent to the EDITOR, NEW ORLEANS MEDICAL AND SURGICAL JOURNAL. Business communications should be addressed to the BUSINESS MANAGER, NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

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DR. F. W. PARHAM. DR. H. W. BLANC. DR. A. W. De ROALDES.  
DR. R. MATAS. DR. JOHN DELL'ORTO.

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## Editorial Articles.

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We take pleasure in publishing the following communication from Dr. Wm. Moor, which is self-explanatory:

"DEAR SIR: The assistant librarian of the New York Academy of Medicine, was kind enough to show me an "Editorial Article," in the last number of the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL, referring to Dr. McLaughlin's and my own theory of immunity. In answer to this editorial I beg to remark the following:

1. At the time of publishing my article in the New York Medical Journal, of July 18, 1891, I had not the slightest knowledge of Dr. McLaughlin's paper.

2. My esteemed colleague's treatise and my own differ so fundamentally, that the question of priority is not to be considered in our case. The term "molecular vibration," as occurring in my papers, is used simply to convey to our mind a more definite idea of the normal and changed dynamic condition of the organic molecules of the system or a part of it, and is *not at all* essential for the maintenance of my theory of immunity, much less the starting point of it, as Dr. McLaughlin says, whereas the doctor actually applies the laws or acoustics *in toto* to the explanation of pathological phenomena; therefore, his conception of the molecular vibration of bacteria and organic molecules forms the basis of his article.

3. Though very much admiring the doctor's stylistic faculties, still I am obliged to say, that his theory is virtually the one advanced by Chauveau, which attributes the acquired immunity to substances resulting from the body-metabolism of the respective micro-organisms and held in solution hereafter by the previously infected body. Dr. McLaughlin simply adopts this view and tries to explain why these substances remaining in the system should be detrimental to a renewed growth of germs of the respective species. In my own article I have pointed out that the bacilli of tuberculosis proliferate in the lung tissues for a period extending often over many years, that the germs of anthrax septicæmia, etc., thrive in blood taken from animals that are at the height of the infection, whose blood is abounding already in the respective bacteria and their ptomaines, that the bacillus typhi abdominalis, the bacillus anthracis, spirillum cholerae asiaticæ, bacillus indicus ruber, bacillus fluorescens liquefaciens, and proteus vulgaris grow as well on culture soils that have been impregnated with their particular ptomaines as in pure media.

4. In my paper I did not dwell on the question of immunity due to inoculations with ptomaines, not having given sufficient study to this subject, but I dare state already, that such an immunity is not due to the antagonism of the ptomaines themselves or to that of newly formed molecular combinations on the ground just referred to. (See No. 3.) I trust to find soon a satisfactory explanation of these phenomenon. I am, sir, yours very truly,

WILLIAM MOOR, M. D.

*New York, September 3, 1891.*

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#### PROPHYLAXIS OF TUBERCULOSIS.

It has been stated by Drs. Gibbes and Shurley that the discovery, in 1882, of the bacillus of tuberculosis has not advanced the therapeutics of the disease one whit. While it is true that the treatment of pulmonary tuberculosis is far from being ideally successful, it is equally true that attention to certain simple and well defined hygienic measures will effectually prevent the

spread of the disease among unaffected persons even though these be of the kind described as "predisposed." The importance of prophylactic measures is felt by all men, and chiefly those who are engaged in laboratory studies that cause them to observe very closely the habits of the tubercle-bacillus. The laity, not possessing the knowledge of physicians, can not fully appreciate the necessity of certain precautions in the presence of possible infection; it behooves the profession constantly to instruct laymen in the methods of preventing the spread of this most formidable disease that afflicts mankind.

At the fifth session of the Association of American Physicians, among the many valuable papers contributed there were two on "Tuberculosis" from Dr. Ernst and Dr. Shakespeare. Dr. Ernst exhibited some specimens, one of which was a rabbit with general tuberculosis of the intestines, which resulted from the subcutaneous injection of a few drops of milk from a suspected cow. A child fed on milk from this same cow died of tubercular meningitis; and a second child was showing symptoms of the same disease. Tubercle bacilli were found in the lesions.

In the course of a paper on "The Prevention of Tuberculosis," Dr. Shakespeare considers the alleged heredity of tuberculosis, and lays down general principles that should underlie a broad plan of prophylaxis. Assuming that the bacillus is the sole and efficient cause of tuberculosis, he denies the heredity of the disease as heredity is usually understood. A person may inherit from tuberculosis ancestors a lowered vitality, a predisposition to tuberculosis; but more than predisposition is required to produce the disease. Without the bacillus, there is no tuberculosis. Among transmissible diseases syphilis stands as a striking example; it is, perhaps, as often transmitted to the fœtus *in utero* as it is acquired after birth. In the face of this, however, there is strong reason to believe that diseases which are essentially infectious are also essentially non-hereditary. In tuberculosis, heredity fails to account for about eighty per cent. of the cases; and tuberculosis *in utero* is the rarest of all affections. These facts give ample ground for the belief that tuberculosis, while it is infectious, is essentially non-hereditary. Heredity,



however, does play an important part in lowering the vitality of the organism, and predisposing the patient to the invasion of tuberculosis; but this predisposition of itself does not produce the diseases of which the active causative agent is the tubercle-bacillus. It may be stated, in passing, that Dr. Thos. H. Mays has recently published a booklet in which he attributes pulmonary consumption to disease of the pneumogastric nerves; the bacillus becomes then a mere epiphenomenon. The doctor's views are at variance with those of the rest of medical mankind, and will not, we expect, receive quite as much attention as the discovery of the bacillus. We will, later on, give a summary of Dr. Mays' views in our review column.

Accepting the etiological importance of the tubercle-bacillus, Dr. Shakespeare thus states the general principles of prophylaxis:

1. Destruction of the vitality of the tubercle-bacillus wherever it may be found outside of the human body.
2. Avoidance on the part of the unaffected of unnecessary risk of introduction, into the organism, of the living bacillus tuberculosis.
3. Improve the resistant power of the individual, his personal hygiene, and that of his dwelling, in order that conditions unfavorable to the presence, vitality and development of the tubercle-bacillus shall prevail as widely as possible.

The principles above stated, though brief, cover all the ground. If carried out intelligently and systematically, in all parts of the globe, consumption would, in the course of a generation, become one of the rarest diseases; but it is hoping too much, at present, to count on universal prophylaxis. In any well-regulated community, however, measures of prevention may be adopted without regard to the other communities. Among these there are two which are not difficult to secure: the destruction of phthisical sputum, and the establishment of hospitals for consumptives. When a patient fully recognizes that his sputum may be a source of infection to unaffected persons, it becomes easy to prevail upon him to adopt some one of the proposed methods for destroying the virulence of the sputum.

In general hospitals it certainly exposes non-phthysical patients to a new danger to place them in wards with persons in various stages of consumption.

Again, it was stated in Dr. Shakespeare's paper that there is no evidence showing that tubercle-bacilli propagated themselves outside of an animal organism.

\* \* \*

A student of mortuary records, who casually glances over the monthly record of deaths in New Orleans finds no difficulty in picking out, from among the figures, the number that indicates the deaths from phthisis pulmonalis; it is always the largest on the list.

New Orleans annually pays an enormous tribute to phthisis. Must it ever continue thus? No. The people of our city, though inclined to be indolent, are still energetic enough to employ such means of making themselves non-dangerous, when they are marked out by phthisis as victims. But *they can not do anything unless they are instructed by their medical advisers*. A medical man who is consulted by a consumptive does not discharge his whole duty to his patient and to his neighbors unless he impresses the patient with the necessity of rendering his sputum innocuous, and not scattering it broadcast.

Again, it is important to detect phthisis in its early stages, since that is about the only time that we can expect to do our patients any good. Where the physical signs are not well marked, a microscopical examination of the sputum may show beyond doubt that the patient is suffering from pulmonary tuberculosis. In order, then, to establish the existence or non-existence of pulmonary tuberculosis, it is necessary to call in the aid of the microscope. If the medical adviser neglects to fortify his diagnosis with an examination of the sputum, he is derelict in the performance of a sacred duty, since he thus allows to pass the only time in which there is any hope for a cure.

\* \* \*

New Orleans has no hospital for consumptives. In the Charity Hospital, the consumptives are distributed among the

medical wards, where they may become possible sources of danger to the other patients.

The Hospital does a vast amount of good in relieving needy persons; but the isolation of consumptives and lepers would be a proceeding in line with the progressive ideas of the present administration of that time-honored institution. These ideas, however, require money to carry them out; and the exchequer of the hospital, unfortunately, is not in a condition to enable the powers that be to adopt all the measures suggested by the recent advances realized in science.

If any city ever needed a hospital for consumptives, New Orleans does. Let us hope that the public may in time be educated up to the necessity of providing separate hospitals for the care of consumptives.

\* \* \*

In stating that the bacillus of tuberculosis did not thrive outside of the animal organism, Dr. Shakespeare made a statement which is open to debate. The bacillus is a parasitic plant that sometimes implants itself in the human organism. But it does not belong there. In its wanderings through the air or food it happens to find an organism that forms a suitable soil for its growth; but it does not originally belong to that organism. The *filaria sanguinis hominis* invades the human organism, but it certainly exists independently of man. The bacillus of tetanus affects many, but it thrives and perpetuates itself in the soil and in horse-manure; it forms no part of the animal organism. The bacillus of cholera lives perennially in India, especially near the mouth of the Hoogly river. That part of the vast delta of this river, known as the Sunderbuns, is uninhabited by man, and is given up to the wild beasts. The luxuriant vegetation of this region gives rise to an inconceivable number and variety of microorganisms, some of which may be peculiar to the locality; and Koch regards it as not improbable that the cholera-bacillus may here be propagated, to be let loose from time to time upon mankind, as circumstances favor its migration. But the cholera-bacillus does not form an integral portion of the human organism.

All of the microorganisms have a life history of their own. They probably existed before man was created or was evolved



as the case may be; we have no direct historical evidence bearing on this question, however. If the bacteria could speak English, we would probably hear a great deal about man as a parasitic organism, thriving upon bacteria, etc.: fortunately, we are spared that.

Why is it necessary to maintain that the tubercle-bacilli can not prosper without the aid of an animal organism? The bacilli probably existed before man and other organisms high in the scale of animal life. That they can exist and thrive outside of the human body is shown constantly in bacteriological laboratories by artificial cultures. Can not some place be found in Nature where the conditions are as favorable to the growth of the bacilli as the gelatine in a culture-tube? Indeed, it was the opinion of Dr. H. W. Blanc, formerly Chief Sanitary Inspector of New Orleans, that the environs of this city did furnish all the conditions necessary for the development of the bacilli. It is to be regretted that Dr. Blanc's departure from New Orleans cut short a line of investigation that might have proved profitable, not only to this city, but also to every other community on the globe.

New Orleans is surrounded by marshes, the water of which contains a large amount of decaying vegetable matter. Amid the diversity of filth, natural and excrementitious, that finds its way into swamps, it is not unreasonable to suppose that there are some ingredients that favor the development of tubercle-bacilli; if so, New Orleans is afflicted with a natural culture-garden for the growth of the deadliest foe to the human race.

Within the city limits there are not lacking conditions favorable to the growth of the bacilli. Drainage of the city and surrounding swamps would transform New Orleans—transform it into a healthy place. But the demand for better drainage must come from the people—those who vote; and they will not demand a thing of which they know not the importance; the duty of the physician and the press—lay and medical—is plain.

The constituted authorities (the Board of Health, especially), could not establish a surer claim upon the affections of the people, or vindicate their right to exist better than by making a vigorous and well maintained campaign against the fell

destroyer. The Board of Health has about solved the yellow fever question. There is no question in the whole domain of hygiene, more important than the eradication of tuberculosis.

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In the discussion on Dr. Shakespeare's paper, the doctor remarked that he did not know of any city in the country where the inspection of meat and milk is provided for by law. He further said that he had read that Pittsburg had made a pioneer effort in that direction. "All honor to her," he exclaims, "and may her praiseworthy example soon be followed by others."

We venture to inform the doctor that New Orleans is very much ahead of Pittsburg in the matter of inspection of meat and milk. About ten years ago an inspector was appointed to inspect meat at the slaughter house. For some reason, the inspections were abolished, but were revived in 1889, when Dr. Wunderlich was appointed inspector. Dr. Wunderlich was succeeded by Dr. Wheeler, a graduate of the Veterinary Department of the University of Pennsylvania. The milk supply of the city is frequently examined by the officers of the Board, but not for bacilli.

This is moving in the right direction. The Board is now directing a large share of its attention to the water supply of the city, and its relation to certain diseases supposed to be attributable to it. When this important matter is finally disposed of, it is to be hoped that the Board will earnestly consider the most important medical subject of the times—tuberculosis.

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## Abstracts, Extracts and Annotations.

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### MEDICINE.

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#### DIURETIN—ITS ACTION AND USES.

In the *Archiv. Exper. Path. und Phar.*, XXIV., p. 85, v. Schroeder gave reasons for believing that caffen produces

its diuretic effect by stimulating the epithelial cells of the kidney, but that this influence is decreased owing to the contraction of the renal vessels which caffein causes by its stimulating action on the vasa motor centre. He showed, too, that theobromine, which only differs chemically from caffein by containing one equivalent less of methyl, and which has less effect on the cerebral nervous system than caffein, acts as a powerful diuretic in rabbits. He suggested, therefore, that it might be employed as a diuretic in man. Its high price prevented for some time this suggestion being acted upon, but in recent times it has fallen to one-tenth the price it formerly commanded and Dr. Gram has made a series of observations on its use as a diuretic. He got some good results, but its action was unreliable, because absorption does not always take place; at times, too, it caused slight sickness. After trying several combinations of theobromine, he met with a compound of theobromine and sodium salicylate, which is very soluble in water, and is now sold by Knoll & Co., under the name of diuretin. This salt is white, and soluble with heat in less than half its weight in water; and no precipitation takes place on cooling. It contains 50 per cent. of theobromine, and does not cause sickness.

Gram gives records of eight cases, in which theobromine sodium salicylate was given. Five were cases of cardiac disease, and three of renal disease. In a case of mitral insufficiency, with dropsy and albuminuria, thirty to sixty grains of theobromine caused very marked diuresis without increasing the amount of urea. Caffein, given with paraldehyde, had subsequently similar but less marked effect in increasing the quantity of urine; digitalis was without influence.

In another cardiac case in which digitalis failed, theobromine had, on two occasions, a very marked diuretic influence. Here, however, pericarditis supervened during diuresis following on the administration of theobromine. The quantity of urea passed was not altered.

In a third instance in which strophantus was of little service theobromine sodium salicylate markedly increased the amount of urine passed, and this increase was accompanied by a considerable augmentation in the amount of the urea excreted.

In a fourth case, in which cardiac degeneration with mitral stenosis and insufficiency and albuminuria were present, the diuretic effect of diuretin was on three occasions very considerable, and a calcium salt of theobromine likewise increased the amount of urine. Here digitalis also produced some influence, but strophanthus, caffein, and calomel proved useless.



In this case it is noteworthy that under the theobromine salt the urea decreased and the albumen was increased in amount.

In the fifth case the theobromine sodium salicylate salt in doses of 180 grains daily had a powerful influence in increasing both the water and urea—digitalis proved quite useless.

In three out of the five cases the influence of the theobromine salt was noticed on the same day, and on the day following the administration of the drug.

Of the three cases of nephritis reported one was treated with theobromine in doses of forty-five—sixty grains daily; the diuresis only showed itself on the fourth day. The total amount of urea decreased when diuresis set in, whilst the amount of albumen increased somewhat.

In a second case the theobromine sodium salicylate had on three occasions a powerful diuretic influence; in the third, a case of tuberculosis with nephritis, the theobromine sodium salicylate not only increased the quantity of water, but the amount of urea also.

There can be no doubt that in Dr. Gram's hands the theobromine sodium salicylate proved a powerful diuretic; he does not, however, record cases (if any), in which he tried it without success.

He found no influence on the heart or circulation produced by the drug, and in the doses in which he gave it—forty-five to ninety grains—it caused no unpleasant after effects, and did not affect the central nervous system.

Dr. Hoffman says that according to Vulpius, the preparations supplied under the name diuretin do not agree either in the amount of theobromine or in their solubility. He used the diuretin sold by Knoll & Co., which is a combination, he says, of theobromine sodium with salicylate of soda. It has a bitterish taste, and is best given in a 5 per cent. solution, with a little syrup and peppermint or fennel water. From such a solution a little theobromine in a few days is precipitated. As diuretin is decomposed in the air, it is not well to order it in powder.

Diuretin is manifestly absorbed after it is taken, for the color tests shows its presence in the urine. In the faces no trace of it can be found.

Hoffman administered the diuretin in seventeen cases, whereof five suffered from pleurisy with effusion, one from peritonitis and pleurisy, two from lukæmia and dilatation of the heart, one from cirrhosis, one from acute nephritis, one from amyloid kidney, two from chronic nephritis, and four from organic heart disease.

In all the cases of simple pleurisy the diuretin caused, on the day following administration, an increase in the secretion of water, in some cases small, but in some cases very large, the amount of urine being doubled or trebled. When the inflammatory condition was subsiding, the increased urine flow seemed to have a favorable effect in decreasing the exudation. Slight diarrhœa occasionally occurred. No other after effects were noticed, although 75 to 105 grains were given daily.

In the patient where tubercular peritonitis and pleurisy co-existed, no diuretic effect followed the use of the drug, and it likewise failed in the case of liver cirrhosis. On the other hand, in the two cases of chronic nephritis, and in a case of acute nephritis, the diuretic effects seemed marked, but no effect was produced in a case of amyloid kidney complicating phthisis. The most marked instances of diuretic action of the theobromine compound was seen in cardiac dropsy. In these cases, diuretin was, for the most part, only given when digitalis had failed, and Hoffman records four carefully observed cases of its marked diuretic influence in cases of cardiac disease. In twenty-four hours a slight increase of the urine was often noticed, which gradually reached its maximum in two to six days, the quantity falling when the dropsy decreased or the medicine was stopped. In some of the cases recorded the drug produced a marked increase several times, which quickly ceased when it was stopped. Sometimes several days elapsed before any effect was evident, probably from a slower absorption of the drug. A cumulative action was not observed, and the diuretic action never lasted more than a day or two after the cessation of the drug. The urea excretion increased somewhat under its action. The pulse was usually slightly slowed, often unaltered; in the majority of cases it became somewhat stronger and less irregular. The appetite improved, though slight but painless diarrhœa came on not unfrequently. An improvement in general health usually followed the strengthening of the circulation, and patients slept better. Excitement was never produced by it.

Hoffman comes to the following general conclusions with regard to diuretin:

(1) It is of marked service in general dropsy. It is of less use in accumulations of fluid due to inflammations of serous membranes. Where there is congestion of the portal circulation it is of no use.

(2) Its diuretic action depends upon its influence on the kidney epithelium, but also exercises a favorable influence on the circulatory apparatus. In daily quantities of seventy-five grains it does not produce any unpleasant effects; on the contrary, it improves the general condition.

(3) It may prove of service where digitalis and caffein have failed, and may be given in combination with heart tonics.

Koritschoner records the effects of the use of diuretin in the words of Professor V. Schrotter. Here it was given in thirty-eight cases of severe dropsy—renal, cardiac and portal—and in three cases of acute rheumatism, besides being tried on several healthy men. The treatment was commenced with sixty grains daily, and the dose was increased by fifteen grains daily. In 60 per cent. seventy-five grains sufficed to produce a favorable effect; in 30 per cent. ninety grains were required; in 10 per cent. the dose had to be raised to 150 grains. No unpleasant effects were observed after taking it. In twenty-three cases the influence of diuretin surpassed that of other diuretics, and in eight of these it was extremely great. In ten it had a moderate effect, but even here it was as good or better than other diuretics. In four cases the diuresis was only slight, but in all these the patients died within four days of admission to the hospital. Only in one case was the drug without any effect. It was found most useful in cardiac dropsy, and less useful in the dropsy dependent on nephritis than in that dependent on the portal circulation. Nevertheless it was more useful than other diuretics in Bright's disease. It could not be shown to have any influence on the action of the heart.

Konindjy-Pomerantz has observed the effects of diuretin given under the directions of Dujardin-Beaumetz, in the Cochin Hospital. It is described as a compound of theobromine and sodium and salicylate of sodium.

To prepare it a molecule of the theobromine (180) is dissolved with a molecule of soda hydrate (40) and to the solution a molecule of hydrate of soda (160) is added. When evaporated to dryness, 362 parts of the double compound are obtained, in which there ought to be 49.7 per cent. of theobromine, but some specimens of diuretin do not contain above 30 to 38 per cent. of theobromine. The conclusions arrived at are much the same as those previously described. It is pointed out, however, that diuretin can not be given hypodermically.

Dr. Konindjy-Pomerantz looks upon it as a stronger diuretic than caffein, when forty-five to seventy-five grains are given daily in fifteen grain doses every two or three hours. Although diuretin acts on the renal epithelium, and it does not influence the contractions of the heart, it should be used with caution in patients suffering from organic disease of the heart.

The increased urine flow produced by diuretin is said to



last three or four times as long as that produced by caffein, and the patient does not get habituated to its use.

It should be given in milk or chocolate before eating. When the kidneys are affected, diuretin has no influence.—*Manchester Medical Chronicle*.

#### INHALATIONS OF OZONE IN THE TREATMENT OF WHOOPING-COUGH.

Dr. Hellet sets forth, in the *Revue Internationale d'électrothérapie*, the results which he obtained in the treatment of whooping-cough with ozone, as follows:

Ozone produced by electricity has never given rise to unpleasant effects in our hands. We have ascertained that ozone is a powerful reconstructive, an incomparable modifier of the blood, since it is necessary to breathe strongly ozonized air for only a quarter of an hour in order to increase, in certain cases, the proportion of oxyhæmoglobin one or two per cent. when it is already 14 per cent.

Though opinions may have differed concerning the beneficial therapeutic effects of ozone, there has not been any dispute about its disinfecting and antimiasmatic actions. Numerous experiments have shown that it acts powerfully upon germs and ferments, that it arrests their development and even destroys them. In view of this fact, and remembering also, that ozone is a powerful reconstructive, I did not hesitate to prescribe inhalations of ozone to little children suffering from whooping-cough, thinking that this disease, which is of microbic origin, would be favorably modified.

Up to the present time only four cases have been treated: a girl of six years, another of five, another of two, and a boy of fifteen months. These children inhaled ozone every day for fifteen minutes. In every case the number of paroxysms was carefully noted.

In all of these cases the course of the disease was favorably modified. The number of paroxysms diminished, and their general condition rapidly improved, which is a very important consideration; they became cheerful, and the appetite was restored.

The parents always noted that the children became more playful after the inhalations of ozone; their paroxysms became less violent and less exhausting.

The duration of the disease seemed to have been shortened.—*La Médecine Moderne*.

## ANTIPYRINE IN INFANTILE DIARRHŒA.

In a long memoir in the *Journal de Médecine de Bordeaux*, M. Saint-Phillippe details the many reasons that led him to try antipyrine in infantile diarrhœa. He concludes thus:

"I prescribe antipyrine (which I often call by its French name of *analgesine*, in order not to disturb the imagination of the patients) in doses of 50 centigrams, mixed with 50 grams of syrup of orange-flower, and 50 grams of linden-flower water, for children of from one day to six months, and I order four, five, six or seven teaspoonfuls a day, or every two hours if the case require it, taking care to arrange the doses about fifteen minutes before taking the breast. In children of from six months to a year, I raise the quantity to 1 gram, and from one to three years, to  $1\frac{1}{2}$  or 2 grams. In this way, in 24 hours from 10 to 20 centigrams are administered to the smallest children, and from 60 to 80 to the largest. No other active medicament is added. Sometimes, when there is danger of choleric form diarrhœa, I substitute syrup of punch for the orange-flower syrup.

"The children take the remedy very easily and without repugnance. In these doses no accidents have ever happened. The urine shows no change, except, perhaps, a slight diminution in quantity. When vomiting is present it ceases at once under the treatment; the diarrhœa is quickly controlled, and the remedy may be diminished as the passages become less frequent. The result is rapid and striking. There is no contra-indication for the antipyrine unless it is the occasional failure to produce the happy results above described whereupon a change in the treatment must be made.

"From what precedes, favorable conclusions result, which may be concisely stated as follows: 1st. Antipyrine is a choice remedy to oppose to the various kinds of infantile diarrhœa; 2d. It acts particularly in the hypercritical form, and in the dyspeptic, painful and reflex forms; 3d. It is usually borne and absorbed with great facility, and deserves to replace other anti-diarrhœic remedies; 4th. Its mode of action resembles physiologically that of morphine, which is inapplicable in such cases; 5th. There is no contra-indication to its use; the dose should not be too large."—*La Médecine Moderne*.

## THE ADMINISTRATION OF QUININE TO CHILDREN.

The difficulty of giving quinine to children, especially when it is desired to administer somewhat large quantities, has, of course, frequently been remarked. In order to obviate this,

it has been proposed by various physicians accustomed to practice among children to order external applications, either in the form of ointments or lotions, with the view of getting the quinine absorbed by the skin, and several continental writers have reported that this system has given good results in their hands. The amount of quinine absorbed under these circumstances, however, was not known, contradictory views on the subject being entertained, while many of the best works on children's diseases omitted all mention of the external form of administration. Dr. Troitski recently undertook a long series of observations in the children's department of a poor-house with the object of ascertaining what was the best form of external application, and how far absorption is possible under these circumstances. His experiments, which were conducted on healthy children, about fifty in number, are published in the current number of the *Vratch*. He made some trials with ointments of which the basis were vaseline, lard or lanolin, but very soon discarded this form of application, as he found that, in order to get any appreciable quantity of the drug absorbed, it was necessary to spend a long time rubbing in the preparation, which was not only tedious to the operator but very fatiguing to the child. Contrary to what most of the writers on the subject have advised, the region of the body selected for the application was the back of the thorax. Solutions of quinine were then tried, with rather more success, one part of the hydrochlorate of quinine being dissolved in 30 of rectified spirit, or in 20 of spirit and 10 of glycerine. Of this a teaspoonful or a teaspoonful and a half was rubbed in twice a day until the skin became quite dry, the precaution having been previously taken of washing the child well. The urine was examined both by the chlorine-water and by the iodine tests, and observations made of the comparative results in the same children. The conclusion came to was that, though the drug is undoubtedly absorbed by the skin from such solutions as were used, the amount was so small and uncertain as to render it impossible to administer the dose that may be desired by the external method. The good effects that are said to have been produced in fever by the lotions, Dr. Troitski would ascribe, mainly, at least, to the refrigerating action of the spirit on the skin.—*Lancet*.—*Columbus Medical Journal*.

#### SEXUAL LIFE OF WOMEN AFTER CASTRATION.

At the Berlin Medical Congress, D. F. Depler, of Venice, read a paper embodying the results of a study he had made in the cases of ovariectomy performed by himself. He had per-



formed castration 46 times, obtaining a cure in 39. These operations were performed for the relief of purulent or gonorrheal salpingitis, oophoritis, fibroid tumors of the uterus, etc. The following were his conclusions, derived from a study of the physiological consequences of these operations: (1.) When the operation was performed on account of salpingitis or other inflammatory process, uterine hæmorrhage never occurred subsequently. (2.) The conjugata became gradually shortened, and this was the more marked the younger the individual was when operated upon. (3.) The uterus became atrophied, the vagina grew shorter and narrower, its mucous membrane became paler, and the labia majora were somewhat thinned. (4.) The breasts grew smaller, acquiring a strong resemblance to the male mamma. (5.) The brown pigmentation of the nipple, areola perineum, and anus disappeared wholly as did also pathological pigmentations existing in some of the cases; the hair also turned white, (6.) The tendency to *embonpoint*, which is generally believed to exist after these operations, was not observed by the author. (7.) No changes were observed as regards the growth of the hair or the tone of the voice. (8.) The sexual desire remained, and was the more pronounced the earlier in life the operation was performed. (9.) The operation offers no impediment to marriage; three of the author's cases had married and lived happily with their husbands for years. (10.) A marriage with a castrated woman is the ideal Malthusian marriage, and the only way the Malthusian idea can be carried out without endangering the health and happiness of the woman. (11.) In the cases operated upon in early life for inflammatory conditions, no neuroses were seen to develop, which was not the case when women were operated upon late in life for fibroid tumors of the uterus. (12.) A favorable influence upon the hemorrhage was observed after operation for myoma, yet in no case did the menopause at once set in. (13.) In cases of operation for uterine fibroma, the patients, even those in full maturity, lost all sexual inclination after the operation.—*Medical Press and Circular; Medical Age.*—*Columbus Medical Journal.*

#### THE PROPHYLAXIS AND TREATMENT OF DIPHTHERIA.

Dr. J. LEWIS SMITH, of New York, read a paper on this subject. The room should be disinfected by adding to one quart of simmering water one to two fluid ounces of the following mixture :

R. Oil of Eucalyptus.....	3 j.
Carbolic acid.....	3 j.
Turpentine q. s. ad.....	3 vj. to 3 viij

Everything and every person not absolutely necessary for the comfort and management of the patient should be excluded from the sick room. Physicians undoubtedly conveyed the disease. They should always examine the fauces by standing behind or at the side of the patient so that no ejected mucus may come upon them. After each visit they should wash thoroughly in a sublimate solution, hands, face and beard. Walking cases without fever, anorexia, or malaise diffused the disease. Daily inspection of the fauces of school children had been proposed. Convalescents should not mingle with healthy children for four weeks. He admitted the full claim of the Klebs-Loeffler bacillus to be the cause of the disease. It was a surface microbe—never penetrating the interior of the body, but attacking only mucous surfaces or cutaneous abrasions. It produces a ptomaine containing carbon, hydrogen, azote, sulphur and oxygen, which by absorption through both blood and lymph channels causes the nephritis, granulo-fatty degeneration of heart-muscle and paralysis.

The treatment should embrace hygiene, diet, and alcohol. Rectal alimentation could be followed for a time. Failure of appetite rendered the outcome doubtful. Diet could embrace milk, with sarco-peptones, beef tea, or meat juice, and the various predigested compounds. Large and frequent doses of alcohol were positively necessary. It is quickly eliminated, and will often save life unless blood poisoning has actually set in. In the proportion of one to five it has been shown to have a destructive action on the growth of the bacillus.

Locally we should remember that normal epithelium was a barrier to the germ's entrance, and hence our remedies should be such as not to destroy the epithelial covering. Denuded or diseased surfaces were favorable starting points for the disease. Corrosive sublimate, 1 to 8000; carbolic acid, 1 to 50; salicylic acid, 1 to 80, had proven of service in arresting the germ growth. Potassic chlorate was useless in this direction, and he had come to discard its internal employment entirely. It had undoubtedly caused nephritis in many cases. The corrosive sublimate could be given by nasal injection, gargling and internally. Where the false membrane was very thick and tenacious equal parts of tincture of iron and glycerine should be given three or four times a day. Loeffler himself uses a mixture of carbolic acid, alcohol and distilled water for the mouth. Our local remedies should be penetrating. Therefore glycerine and water, never syrup and mucilages, should be our vehicles for all local applications. The official solution of iron chloride might be diluted three or four times for this purpose. While it undoubtedly contracted the vessels it was often painful. It congeals the mucos-pus of the fauces.

Carbolic acid, Monsel's solution, and glycerine could be advantageously used in this way. For nasal disinfection a saturated solution of boric acid was preferable.

For internal treatment, iron assisted the anæmic condition. Vegetable tonics, including quinine, were probably useless, as were also quinine insufflations in the oral cavity. The main reliance was to be placed on the bi-chloride. He was in the habit of giving a two-year old child  $\frac{1}{72}$  grain every two hours; four years,  $\frac{1}{40}$  grain; six years,  $\frac{1}{36}$  grain; ten years,  $\frac{1}{24}$  grain. His solution was made by dissolving the sublimate in alcohol, and adding elixir of bismuth and pepsin. Sublimate solution, two grains to the pint, could be used for the nose. The mercurial should be continued at least one week, unless diarrhœa supervened, but not longer. Calomel had been suggested. Many gave an initial dose, and some continued it through the entire disease. It undoubtedly increased the anæmia. Of late it had been given in the New York Foundling Asylum by sublimation, from ten to forty grains being used, under a tent made over the patient's bed. The indication for its use was the supervention of hoarseness. The attendants had been salivated in several instances, but the patients were apparently not injured. It seemed to lessen the necessity for intubation. The process might be repeated in three or four hours. The percentage of recoveries from intubation, where necessary, was better in the calomel cases than in others. For the nephritis he gave iron, and for the paralysis tonics, strychnine, and electricity.

Dr. A. Seibert, of New York, remarked that we must see way down to the epiglottis in order to have our examination amount to anything. Children should not be allowed to kiss each other when there was any sore throat about, and very young children should not be allowed to creep around on the floor. They scraped up the dust with their fingers, which they would afterward put in their mouths. Thus the germs which settled on the floor were conveyed to the sensitive membranes. The experiments of Gebhardt, of Bonn, had shown that false membrane could be dipped in a sublimate solution, and then, after drying and teasing, cause a bacillus development in a culture medium. It was, therefore, especially under the conditions of diphtheria, slow in germicidal action, but thorough, if once brought into perfect contact with the affected areas. A 5 per cent. solution of acetic acid has been shown to be quickly penetrating.—*New York Medical Record*.

#### WASHING OUT THE LARGE BOWEL IN DYSENTERY •

Dr. Peter S. Korytin, of Novotcherkask, describes (*Vratch*, No. 42, 1890, p. 951) fifteen successive cases of diphtheritic



(nine cases) and catarrhal (six) dysentery, which he treated daily with warm (30 deg. Reaum.) large enemata of six pints either of filtered water from the tap, or a carbolic acid solution (from ten to twenty grains to six pints of distilled water). Only one of the patients died, the remaining fourteen making excellent recoveries. The total number of the injections in individual cases varied from one to six, averaging two and a half. The injected fluid was retained by the patient mostly from five to ten minutes, being sometimes expelled in one or two, and in other cases in from fifteen to twenty minutes. The following effects were commonly observed: Abdominal distention and pain speedily subsided, the frequency of stools diminished and tenesmus decreased, the spirits, appetite, and sleep quickly improved, the stools soon became painless, more solid, and free from offensive odor, mucus, blood and sloughs or shreds, while the temperature became normal. No therapeutical difference whatever was noticed between carbolic and simple enemata. It appears, therefore, that the beneficial results of the treatment should be attributed simply to the thorough washing out of the large intestine.—*Med. Age.*

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#### THE LOCAL TREATMENT OF DYSENTERY.

Dr. H. C. Wood contributes the following article to the August number of the *University Medical Magazine*:

“There seems to me to be in modern medical thought a very strong tendency to consider disease as constitutional rather than local. I do not doubt but that there are one or more forms of dysentery dependent upon the presence of poisons in the blood, but I feel very confident that the dysentery, as we see it ordinarily in this climate, is essentially a local inflammation, independent of any blood poisoning. If this be true, the disease should be especially amenable to local treatment. It is true that the ordinary treatment, which seems not to be local, really owes much of its efficiency to a local influence. Thus, the purgative acts by a purely local depletion; the mercurial, or the ipecac, by a local stimulation of the glands involved; whilst the bismuth spreads itself upon the mucous membranes and by its local action lessens inflammation. It has seemed to me, however, worth while to draw the attention of practitioners to the value of the direct application of remedial agents to the affected parts.

“Many years ago I published a series of cases of chronic dysentery, demonstrating the extraordinary efficiency of forced enemata containing one half a drachm to a drachm of nitrate

of silver dissolved in two or three quarts of water, and further experience has corroborated all that I said. Indeed, from time to time have appeared papers in the medical journals proposing the treatment as both novel and efficacious.

“In acute dysentery, involving the colon high up, I have found large enemata, containing two or three drachms of sub-nitrate of bismuth, much more efficient than the exhibition of bismuth by the mouth. When the symptoms are severe, this local treatment may often be preceded with advantage by washing out the colon with large quantities of cold water. I have never used injections of nitrate of silver in acute dysentery, although the effect of the local application of the nitrate in other inflammations of mucous membranes would justify trial of the remedy. I have seen, in one or two cases, large enemata of very hot water injected without affording relief, and believe that hot water enemata are, in their ordinary results, not at all comparable with large injections of ice-cold water.

“When the lower part of the colon is affected, the local use of ice sometimes has an almost marvelous effect. I have, indeed, seen the whole aspect of a very severe and alarming case, in which the symptoms indicated that the colon was affected high up, changed in a single hour by the continuous use of *ice suppositories*. While it is not necessary to have the pieces of ice entirely regular in shape, care should be exercised that no sharp edges are left. The suppositories should be rapidly used, one being put into the rectum every three to five minutes, so as to get, for at least half an hour to an hour, the effect of the continuous application of cold.

“When the tenesmus is very severe, iodoform suppositories are often much more efficient than opium in bringing relief.

“A remedy which has been from time to time recommended very highly in dysentery, but has not, I think, been much used, is ergot; and when the passages contain large quantities of blood, or are nearly pure blood, the extract of ergot would seem to be indicated. I have never myself used ergot by the mouth in these cases, but have employed suppositories containing twelve grains of extract of ergot and four grains of iodoform, used every two hours, until four or five suppositories had been taken, with seemingly great advantage.

“I do not mean to advocate the local treatment of dysentery as a substitute for the use of mercurials, purgatives, and ipecacuanha, etc., but as a very important adjuvant to the older forms of treatment. Nevertheless, in my experience, the effect of local remedies has been more prompt and decided than that of drugs given by the mouth; but in case of any severity the attack upon the disease may be made from each end of the mucous tract.”—*Practice*.

## FORMULA FOR HYPODERMIC INJECTIONS OF QUININE.

Dr. Barillé recently stated to the *Société de Pharmacie* that the addition of antipyrine to the muriate of quinine enables the latter to dissolve easily. He recommends the following formula for hypodermic use:

℞—Muriate of quinine.....	15 grains
Antipyrine .....	7½ grains
Distilled water .....	½ drachm

The solution causes some pain when injected; the addition of  $\frac{1}{3}$  or  $\frac{1}{2}$  grain of cocain would be beneficial.—*La Médecine Moderne*.

## OBSTETRICS.

## IS EMBRYOTOMY OF THE LIVING FŒTUS JUSTIFIABLE?

By EGBERT H. GRANDIN, M. D.

Chairman of the Section on Obstetrics and Gynecology, New York Academy of Medicine, etc.

OF all the problems in obstetrics, the one propounded to-night is the most vexed, and the most important as well in the light of the marvellous progress of abdominal surgery during the past decade. Every physician whose practice necessitates attendance on woman during the supremest of her trials, when confronted by the necessity of destroying the lesser human life in order to succor the greater, must have felt instinctive repugnance; and every physician will hail with joy the advent of the day when the call for fœticide no longer exists, in that, through resort to the Cæsarian section the babe may be saved, and yet the mother not imperilled.

Ten years ago the answer to our question was necessarily affirmative. The maternal mortality from the Cæsarian section at that time was about forty per cent. on an average, hence absolutely no regard could be paid to the life of the fœtus. To subject the mother in those days to the Cæsarian section, except under stringent absolute indication, meant death to her, and with no certainty of saving the child. Ten years ago, cleanliness, to say nothing of antisepsis, was an almost unknown quantity in obstetrics; the proper method of suturing the uterine wound to guard against gaping and internal hæmorrhage was as yet only on the verge of evolution; the peritoneal cavity, if not a *terra incognita*, was with the vast majority of men a *nolle me tangere*; septicæmia was rife in our mater-



nity hospitals. What wonder, then, that embryotomy was a beneficent necessity, and the Cæsarian section, particularly a successful one, was a *rara avis*. To-day our knowledge and our results are very different. Septicæmia during the puerperal state means simply faulty technique in the conduct of labor. The mortality from this cause has fallen as low as one-quarter of one per cent. in our New York maternities. To-day we know how to effectively suture the uterine wound; to-day we do not fear entering the peritoneal cavity, saving many a life which formerly was doomed. The abdominal surgeon is prepared with his statistics of series after series of laparotomies, complicated and uncomplicated, with, in individual instances, a mortality of from one to five per cent. Enormous fibroids of the uterus are removed without an untoward after symptom—an operation, let it be remembered, for the removal of a tumor which of itself rarely kills and retrogrades at the menopause. In the face of all this, the time is certainly ripe for frequent discussion of this question of embryotomy. We may not solve our problem just yet in the desired direction, but, if I mistake not the signs of the times, the absolute certainty in the near future is that the physician will not be justified in sacrificing the living child because the maternal chances from the Cæsarian section are unfavorable. Modern methods of asepsis, and modern methods of operative procedure, are yielding results which will shortly prove that the only risk to which the Cæsarian section subjects the mother is shock. This factor, it must be granted, is associated to an equal degree with any and all of the methods which are at our disposal for the sacrifice of the child.

Aside from the operator himself, there are certain factors which militate against the relegation of embryotomy to its proper sphere—instances where the fœtus is dead.

One factor, and a prominent one, is the lack of thorough education in obstetrics. Midwifery must be raised to a higher plane than it has as yet secured. While the art can never become a specialty, greater stress should be laid on its practice in our medical schools. The student should be told that in no given case can it be predicated that nature will be equal to her task. He should be told to make it his rule in practice to examine every woman he is engaged to confine, in order to determine the configuration of her pelvis, and in order to estimate the probable size of the fœtus which must pass through this pelvis. Pelvimetry has with us been too much neglected, with the result that over and over again the forceps and version are resorted to in instances where accurate pelvic measurement would teach that both are contra-indicated, from the side of the

child as well as from that of the mother. The result of faulty methods of instruction, the result of blind obstetrical practice, have been most disastrous in our statistical data. Not alone have children been sacrificed, but women also, in instances where a sounder scientific training would have taught that the Cæsarean section carried with it no greater risk to the mother, and offered hope of saving the life of the child. We must learn, then, to deliberately *elect* the Cæsarean section. This accomplished, we will cease mutilating children, a procedure which every one who has been called upon to perform, will admit is repugnant to his very nature.

I will not dwell at length on the moral side of this question of embryotomy. Theologians can not decide it for obstetricians. "If you can not extract the child without killing it, it is murder to kill it," is the edict of the Church, easy to pronounce by those who are never called upon either to extract or to kill; but it is an edict which could carry absolutely no weight with the obstetrician so long as the alternative of not killing the child was the death of the mother. We must view this question purely from a scientific standpoint, and criticise it in the light of established scientific facts. Such at least is the state of the question as far as the physician is concerned. With the laity the question is a very different one. If the solution of our query is to be left in the future, as it has been largely in the past, to the relatives of the fœtus the fate of which is at stake, embryotomy of the living fœtus will always remain a justifiable procedure. The layman does not care for scientific facts, and throws statistical data to the wind where there is a choice between embryotomy and the Cæsarean section. He will insist to-day, even as he always has, on the sacrifice of the child rather than that the woman should be subjected to an operation which in the popular mind carries with it almost certain death. As for the woman, it will be rare indeed that the maternal instinct is strong enough to enable her deliberately to select the Cæsarean section in order that her unborn babe may have a chance of life. The point, then, which we as physicians will have to face sooner or later, is: should the laity have any voice in the decision whatsoever? As physicians, we are not to weigh the relative value of one life over the other. We are called upon simply to do our best by the two lives committed to our charge, and if we can once deliberately conclude that the Cæsarean section carries with it but slight, if any greater, risk to the woman than does embryotomy, then it becomes at once our duty to elect the operation. Let me state distinctly what I mean by the term *elective* Cæsarean section. To take a con-

crete case: I am asked to attend a woman in her approaching confinement. I find on inquiry and examination that she is within a few weeks of term. External pelvimetry teaches me that her pelvis lacks the normal configuration. Internal pelvimetry shows shortening of an inch and a half to two inches in all the diameters, or possibly only in the true conjugate. By means of external abdominal and combined abdomino-vaginal examination, I determine that the fœtus is probably of average size. Attempts at causing the presenting part to engage in the brim of the pelvis by means of downward pressure on the uterus suggest to me that this presenting part can not readily enter the pelvic canal. I feel, therefore, that the chances are against the birth of a living child, either through the efforts of nature or resort to forceps or version. I at once begin to prepare the patient for Cæsarean section, even as I would were the intended operation an ovariectomy. I clean out the intestinal canal; by means of daily baths I obtain ample function of the sweatglands; I have the room where the operation is to be performed thoroughly cleaned; I select the day and hour for the operation, placing it as near full term as is possible; about six hours before the operation I induce labor by one or another of the recognized methods, operating therefore under the best obtainable conditions. This woman's chances of recovery, it seems to me, are absolute, barring that bugbear of all surgery—shock.

In this suppositious case, I have selected, it will be noticed, an instance of slight pelvic deformity; and further, the pregnancy has already advanced too far for anything to be gained by the induction of premature labor. I take it for granted that all will accept the Cæsarean section under the absolute indication, that is to say, where the true conjugate measures less than two and one-half inches; I further concede that where the case is seen early enough, the induction of premature labor should always be elected. Now, in this same case, can I or will I elect to perform embryotomy? No; but having first given nature a chance, I will resort to the forceps or version, or to both; and finally, these failing, perform what may turn out to be a very difficult craniotomy. The already exhausted woman is subjected to the further exhaustion which is associated with a protracted embryotomy; further, she is subjected to the risk of deep cervical rupture with profuse hemorrhage; further still, there is risk of uterine rupture, to say nothing of fistulæ or deep laceration of the pelvic muscles and fascia, which form wide avenues for the entrance of the pathogenic germ. Is the woman's chance of recovery as great as if I had deliberately elected the Cæsarean section? These companion



pictures are from life. I have seen deeper shock after embryotomy than after the Cæsarean section; I have met with profuse hæmorrhage after craniotomy; I have yet to witness sepsis after either, and I have yet to lose a case from cause directly traceable to the operation after either. But my experience with both operations has caused me to waver somewhat from my early training, and has led me to formulate for myself the following rule of practice, in which I believe the results in the next few years will justify me: In hospital practice I shall urge, and where possible reform, the elective Cæsarean section in suitable instances under the relative as well as the absolute indication; In private and consulting practice, I shall urge the section under similar indication, although I know that, for the present certainly, the advice will rarely be accepted. And why? Because of that fallible test upon which we are all too prone to ultimately rest—statistics.

I have hitherto absolutely ignored the statistical data at my disposal, for the reason that they give no fair estimate of the results obtainable after the elective Cæsarean section. If we take the statistics as collected by Harris, of Philadelphia, we find that the improved Cæsarean operation has saved nearly 76 per cent. of the women, and nearly 94 per cent of the children. The fallacy of these data as giving us a clue to the obtainable results from the operation I have pleaded for, is the fact that we do not know in how many of the instances the operation was deliberately elected. If the cases were thus sifted I question if the maternal mortality might not be lowered beyond 10 per cent. I so judge from the records of individual operators. There are German operators whose mortality is as low as 6 per cent.; Hertsch has recorded seven cases with no deaths; Cameron, of Glasgow, ten cases with one death; at the New York Maternity Hospital the record for the past two years is four cases, all successful both as regards the mothers and children. In the same hospital, during this period, there have been performed four craniotomies with one death, and in another case the shock was so extreme for hours that the patient only rallied after resort to transfusion. On the other hand, the mortality after embryotomy in the European maternities has varied from 5½ per cent. to 45 per cent., according to the degree of pelvic contraction in the presence of which the operation has been performed. Obviously, the maternal mortality after embryotomy can not fairly be juxtaposed to that after the elective Cæsarean section, for the very reason that, except in extreme degrees of pelvic contraction, destruction of the living fœtus will always remain, so long as it exists as a justifiable measure,

a matter of last resort. The point I desire, however, chiefly to emphasize is that the statistical data at present at our disposal give us absolutely no omen of the future status of the elective Cæsarean section. If those of us who are connected with maternity hospitals will only, with one accord, cease resorting to embryotomy except in instances where, for one or another reason, the woman's condition does not warrant the section, I have little question but that the results will soon prove that the safety of the mother is not imperilled by the deliberate selection of the alternative operation which avoids mutilation of the child.—*New York Medical Record*.

## Book-reviews and Notices.

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*The Physical Examination of the Diseases of the Heart and Lungs and Thoracic Aneurism.* By D. M. Cammann, A. B. Oxon, M. D. G. P. Prित्रain's Sons, New York and London. (Armand Hawkins & Co., New Orleans. Cloth, price \$1.25.)

Although this little book presents nothing new, the subject is well written and will be useful. It contains a good article on the stethoscope and the author's modification of it and an interesting table of measurements of the heart by auscultation and percussion. Some of the chapters, especially the one on the pulse, are rather brief, but on the whole, the book can be recommended.

W. E. P.

*The Vest-Pocket Anatomist* (founded upon Gray). By C. Henri Leonard, A. M., M. D. (The Illustrated Journal Publishing Company, Detroit, Mich.) Fourteenth revised edition.

This little book seems to have been a very popular one. It is a compend containing dissecting hints and points on visceral anatomy. It contains an interesting little table of points, worth remembering; among other things, the author says that the common carotid is the only branchless larger artery (except the terminal branches.) Our copy of Gray says that it occasionally gives off the superior or inferior thyroid or laryngeal branch and as the thyroids are but an occasional branch of the innominata, we would place this artery in the same class. On the whole, the little work fulfills expectation. W. E. P.

## PUBLICATIONS RECEIVED.

Minor Surgery and Bandaging, including the treatment of fractures and dislocations, tracheotomy, intubation of the larynx, ligations of arteries, and amputations. By Henry R. Wharton, M. D. Lea Bros & Co.

Addresses, Papers and Discussions in the section of Obstetrics and Diseases of Women at the forty-second annual meeting of the American Medical Association, at Washington, D. C., May 5-8, 1891.

Regional Anatomy. By George McClellan, M. D. Quarto. Lippincott. Annual of the Universal Medical Sciences. Issue of 1891.

Addresses, Papers and Discussions in the Section of Surgery and Anatomy, at the forty-second annual meeting of the American Medical Association, at Washington, D. C., May 5-8, 1891.

Report of the Protestant Hospital Association, St. Louis, Mo. 1891.

Causas de la Ceguera y Modo de evitarlas. Conferencia pronunciada en la Sociedad Española de Higiene por el Dr. D. Angel Fernandez Caro, Primer Vice-presidente de la misma. 1891.

A pathological condition of the lungs hitherto undescribed in this country, but which is not infrequent. By F. Peyre Borchet, A. B., M. D.

Erythroly on Coca: therapeutic, hygiene. By A. de Pietra Santly, M. D.

Medical Reports on Valentine's Meat-juice as a nutrient in cholera infantum, diarrhoea and dysentery.

A ready method for counter-extension at the knee. By Henry Ling Taylor, M. D.

Treatment of lateral curvature of the spine. By Henry Ling Taylor, M. D.

Adjusted locomotion in the treatment of the recovering stage of hip-joint disease. By Henry Ling Taylor, M. D.

The Surgical Treatment of Empyema. By James A. Goggans, M. D.

Report on Cholera in Europe and India. By Edward O. Shakespeare, of Philadelphia, A. M., M. D., Ph. D., United States Commissioner.

Index Catalogue of the Library of the Surgeon-General's Office, United States Army. Vol. XII.

Transactions of the Thirty-fourth Annual Session of the Medical Association of the State of Missouri, held at Excelsior Springs, Mo., May 19, 1891.

Acid Bichloride of Mercury as an Antiseptic. Its Application to Surgical Practice. By Ernest Laplace, M. D.

Resorcin as an Antipyretic. By W. Carroll Chapman, M. D.

Transactions of the Southern Surgical and Gynecological Association. Vol. III., 1891.

The Shurly-Gibbes Treatment of Tuberculosis. By E. Fletcher Ingalls, A. M., M. D.

Ueber die Physiologische Grundlage der Tuberculinwirkung. Eline Theorie der Wirkungsweise bacillärer Stoffwechselproducte. Von Prof. O. Hertwig. Jena: Gustav Fischer, 1891.

Bloodless Amputation at the Hip (Lanphear).

History of a Case of Sarcoma of the Genu of the Corpus Callosum, presenting Symptoms of Profound Hysteria; with autopsy. By Chas. A. Oliver, M. D.

Medical Progress. By C. R. Earley, M. D.

Proceedings of the Florida Medical Association, session of 1891.

How Should Girls be Educated? A public health problem for mothers, educators and physicians. By William Warren Potter, M. D., Buffalo, N. Y.

On the Use of the Oil of *Eucalyptus Globulus* Combined with Other Antiseptics in the Treatment of Scarlet Fever and all Infectious Diseases. By J. Brendon Curgiven, M. R. C. S., L. S. A.



## State News and Medical Items.

[Communications from Physicians of Louisiana are solicited for this Department. News of personal interest is especially desired.]

### CHARITY HOSPITAL.

#### MEETING OF THE BOARD OF ADMINISTRATORS.

The regular monthly meeting of the Board of Administrators of the Charity Hospital was held September 7, 1891, at 7:30. Dr. Bickham was in the chair; Mr. Marks, the secretary and treasurer, at his post, and present the following members of the board: Messrs. McManus, Keller and Dr. Wiehn-dahl.

After the reading and adoption of the minutes of last meeting the report of the secretary and treasurer was called for. It showed a total for the month of August of \$7147.27 of expenditures, against \$12,807.18 of receipts, leaving a cash balance on hand of \$48,138.34 on the 1st of September. The bulk of the income for August came from the payment by the State Treasurer of State warrants for the third quarter, amounting to \$10,000, while \$1000 of the total came from a bequest of the heirs of the late W. H. Letchford.

The report of the house surgeon, Dr. Miles, showed everything progressing as usual. Dr. Miles was granted leave of absence for thirty days, with the permission while on his trip through the northern cities, to purchase such new and improved apparatus and paraphernalia for the hospital as, in his judgment, would prove to be to its benefit.

The report of the ambulance corps showed service performed as follows for August:

Number of calls—Surgical, 42; medical, 19; dressed, 22; conveyed home, 5; obstetrical, 4; died, 3; false, 4; refused none; not needed, 12; transfer calls, 6; total, 117. Average time of absence from hospital on calls, 34 minutes. Three pay calls at \$10 each, \$30; paid.

The report of Mr. Chas. de Mahy, clerk of the hospital, for August, read as follows: Number of patients remaining in the hospital August 1, 1891, 549; number of patients admitted, 574, of which 233 were foreigners and 341 citizens of the United States; 436 were males, 8 of whom were under 10 years of age; 127 females, three of whom were under 10 years of age; 400 male patients have been discharged and 104 female patients; 51 male patients and 22 female patients have died. On September 1, 343 male and 106 female patients re-

mained in the hospital. The daily average of patients during the month has been 543.

The financial report of the clerk of the hospital showed that \$217 has been received from pay patients, of which \$41 has been returned, leaving a balance of receipts from this source of \$176. From gate fees \$340 has been received, from burial certificates \$12, and from legal certificates \$4; making the total of receipts \$532, which has been turned over to Sister Agnes for use in running expenses of the hospital. There are at present in ward No. 14 five pay patients.

Messrs. Geo. Seamen and Col. Vincent, members of the Board of Administrators, were granted leave of absence.

A communication from Messrs. Farrar, Jonas & Kruttschnitt, attorneys for the hospital, called the attention of the Board of Administrators to the fact that it would require an advance of about \$250 or \$300 to pay off a few remaining debts and legacies upon the Ingram succession, as a preliminary to the hospital's being put into possession of the property of that succession as universal legatee. Messrs. Farrar, Jonas & Kruttschnitt state that they have been informed by Mr. Kennedy, of Carroll parish, attorney for the succession, that the property will sell at private sale for \$3000, and recommend the advance of the \$300 necessary. The board authorized the advance of the necessary amount. Adjournment.—*Picayune.*

DR. TURNER, formerly of Loreauville, has located at Baldwin, La.

DR. E. SOUCHON and MR. THOMAS SULLY, the architect, have departed for the north to inspect the latest improvements in medical colleges, and to utilize their information in building the new Tulane Medical College, which is to be erected on Canal street, between Villere and Robertson.

DR. D. M. FOSTER, of Franklin, La., has returned from the famous Brown's Wells, Miss.

DR. J. M. WATKINS has returned to the city from a trip to Boston and New York.

DR. R. U. BORDE and S. E. HALE have returned to the city.

DR. F. N. BRIAN, of Boyce, La., buried his infant daughter. The doctor has our sympathy in his loss.

DR. WM. E. SCHUPPERT, has returned to the city after a pleasant vacation in Bay St. Louis, Miss.

DR. ROGER DE MONTLUZIN and his accomplished wife, have moved from Bay St. Louis to Baton Rouge, the doctor's former place of residence, where their coming is viewed with great pleasure by their many friends.

DR. A. S. YATES, of Franklin, La., was at the St. Charles recently.

DIED.—BORNO.—On Wednesday morning, September 23, 1891, at 2:15 A. M., Adele Renaud, beloved wife of Dr. D. Bornio, aged twenty-six years, a native of this city.

DR. T. W. McLEROY, of Charlieville, La., died on the 14th inst.

MARRIED.—STARK-FOURTAN.—On Wednesday, September 24, 1891, at the Jesuit Church, Rev. Father Powers officiating, Dr. Thomas Stark, of Thibodaux, La., to Miss Jeanne Fourtán, of this city. No cards.

MARRIED, on Thursday, September 24, 1891, Dr. Dellizon Arthur Foote, editor of the *Omaha Medical and Surgical Record*, was married at Holly, Mich, to Miss Harriet Baird.

Dr. Nat. Moss and Mr. Frank Moss, of Lafayette, spent several days in the city last week, and left for home on Friday.

DR. D. G. CHINN, who died in Lexington, Ky., on Monday last, aged ninety-four years, was at the time of his death the oldest physician in Kentucky, having been born April 1, 1797. His great-grandfather, Raleigh Chinn, came over from England and settled in Virginia, and married Miss Ball, a near relative to Gen. Washington's wife. His father, whose name was William Ball Chinn, emigrated to Kentucky in 1790, and settled in Bourbon county, where Dr. Chinn was born seven years afterward. In 1834 he moved to Lexington, where he served six years in the city council. In 1868 he was elected Mayor, and he served in that capacity several terms. Dr. Chinn was married three times and had twelve children, five of whom are living. He has had forty grandchildren. He married his last wife, who died a year ago, when he was eighty-two years old.



DR. L. F. REYNAUD has departed for Waynesville, N. C.

MRS. HALLE T. DILLON, daughter of Bishop B. T. Tanner, is not only the first colored woman physician, but the first woman of any race to pass the Alabama State medical examination. It was a written examination, and an unusually severe one, occupying ten days. Dr. Dillon, after passing with a high average, now occupies the position of resident physician at the Tuskegee (Alabama) Institute.

DR. BRAXTON WISE, of Benton, has just completed a new home,

Houma *Courier*, Sept. 26: In Providence, R. I., after a short illness, Dr. Walther Bennett died. His brother, J. Y. Bennett, of Hunts, N. Y., was with him for a few days, and brought his remains to that place for burial. Nearly fifty years ago Dr. Bennett was a citizen of Lafourche parish. He was the first man to bring a sewing machine here. On July 10, 1851, he was married to Miss Mary E. Cross, who died and was buried in St. John's cemetery, Thibodaux.

DR. W. C. AYRES, of New Orleans, has been rustivating at Pass Christian for a few days.

A young doctor, wishing to make a good impression upon a German farmer, mentioned the fact that he had received a double education, as it were. He had studied homeopathy, and was also a graduate of a "regular" medical school. "Oh, dot vas noding," said the farmer; "I had vonce a calf vot sucked two cows, and he made noding but a common schteer, after all."

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## BIOGRAPHICAL SKETCH.

DR. FRANCOIS QUESNAY.

By JAMES MIDDLETON, of New Orleans, La.

Among the great men that the eighteenth century gave to humanity, Francois Quesnay, first consulting physician to Louis XV, stands conspicuous. Though as a physician he rises immeasurably above John Locke, yet, like Locke, his fame now rests chiefly upon his great attainments as a philosopher and economist.

Of his early history, the accounts are meager and somewhat conflicting. He was probably born at Méry, about twenty eight miles from Paris, 4th of June, 1694, the same year in which Voltaire saw light.

His father is said to have been a small landed proprietor, who cultivated his own soil, though it has also been claimed that he was only a common laborer. He was probably taught to read by the village gardner after he was thirteen, though one account places the event at eleven. Be that as it may, he at once became an eager student. He learned Greek and Latin of the village doctor, under whom he also studied surgery. He soon so surpassed his teacher, that when his teacher sought to gain admission into the corporation of surgeons, he made surreptitious use of some of Quesnay's essays, and won "very great applause."

Soon afterwards Quesnay went to Paris to continue his studies, and there also began his studies in metaphysics and philosophy. He acquired considerable skill in drawing and engraving. After five or six years of intense application he went to Mantes to establish himself in the practice of his profession; but his attainments had awakened the jealousy of the surgeons, and they refused him admittance to the Maitrise or Corporation of Surgeons. He returned to Paris, was there admitted, and then returned to Mantes, and thus compelled the corporation there to admit him.

His practice rapidly extended among the best families. His skill and address, coupled with a lucky circumstance, soon brought him to the notice of Madam de Pompadour. She employed him as her physician, and in 1737 secured him the place of "surgeon in ordinary" to Louis XV. He became secretary of the Royal Academy of Surgery, member of the Academy of Sciences and member of the Royal Society of London. About 1744 he became first consulting physician to the King, Louis XV, who granted him letters of nobility, gave him a coat of arms—three flowers of the pansy (*pensée*), with the motto, "*Propter excogitationem mentis.*" Louis called him his thinker, *mon penseur*.

He now had greater leisure, which he ardently devoted to study and writing. He published numerous medical and surgical works which showed his great genius and research. In an age when bleeding was practiced, he distinguished himself by his active opposition. In regard to his professional works, I quote as follows, from J. R. McCulloch's biography in the seventh edition of the Encyclopedia Britannica. "In 1747 he published an enlarged edition in three tomes, 12mo, of his *Essai Physique sur l'Economie Animale*, originally published in 1736; in 1748 he published an *Examen Impartial des Con-*

*testations des Medecins et des Chirurgiens des Paris*; In 1749 he published a *Memoire sur la Sagesse de l'Ancienne Legislation de la Chirurgie en France*; and two separate treatises in 12mo, the one on Suppuration, and the other, *De la Gangrene*; in 1750 he republished his *Traité des Effects et de l'Usage de la Saignée*, written during his residence at Mantes, and originally published in 1730; and in 1753 he published his *Traité des Fièvres Continues*.

His chief economic writings were two articles on *Fermier* and *Grains* in the *Encyclopedia*, 1756-1757; the *Tableau Economique* and the *Maximes Générales du Gouvernement*. These last two were printed together by command of king Louis XV in 1758 with the remarkable epigraph: "Pauvre paysans, pauvre royaume, pauvre souverain." He wrote numerous other articles on economics and mathematics.

His writings, his achievements in medicine and surgery, his position won from obscurity easily stamp him as one of the greatest physicians and surgeons of his age. But his fame to-day rests chiefly upon his achievements as philosopher and economist, and as such he has left a deep and constantly broadening influence upon humanity, not surpassed by any of that bright galaxy of thinkers and writers, who have made the eighteenth century a beacon light to social progress.

A French economist, Joseph Garnier, in Lalor's *Cyclopædia of Political Science*, Vol. III, page 192, says, with Eugene Daire, that "Quesnay was really the first thinker of the eighteenth century who made the organization of society the subject of his meditations, the man who gave to the world the newest doctrine and at the same time the fittest to exercise a happy influence on the welfare of nations. Montesquieu, Voltaire and Rousseau were great minds beyond a doubt, but Quesnay served the human race most, in having shown that the happiness of the majority depends much less upon the mechanism of governmental forms than on the development of human industry, and that it is impossible to discuss politics rationally without having previously acquired a knowledge of the economy of society."

In the brief space of this article only a bare outline of his views can be given, the views which were embodied in the teachings of the school of philosophy he founded, the *Physiocrats* or *Economists*. The best résumés of these views to be had in English may be found in James Mill's article on the *Physiocrats* or *Economists* in the seventh edition of the *Encyclopædia Britannica*; in Lalor's *Cyclopædia* before referred to; and in *Blanqui's History of Political Economy*.

Prof. August Oncken, in 1888, published in French a



compilation of his economic writings, under the title *Oeuvres Economiques et Philosophiques de F. Quesnay, Fondateur du Systeme Physiocratique*. Joseph Baer, Francfort, publisher.

Quesnay held that there was a divine or natural order in human society which it was our business to discover and carry out. His philosophy started with his primary relation to earth. Man must have food, and as food can only be produced or acquired by labor, the right to labor is a physical necessity of our nature. It follows also that the product of labor also belongs of right to the laborer. The laborer, therefore, should have perfect freedom, that is he should have control of his person and of the products of his labor, which he called moveable products. As labor must be exerted upon land, property in land is essential to the well being of society. The *rights* to person, to moveable and to landed property give rise to corresponding *duties*, of each to respect the *rights* of others. *The rights and duties are reciprocal.*

All persons are not willing to respect the rights of others, hence arises the necessity of government to compel the recognition of rights where necessary.

Says James Mills, "this assuredly is the most important question to which human faculties can be directed, and the economists have never yet received the credit which is their due for the ability and success with which they labored to resolve it."

Government exists only to secure to each the fullest enjoyment of his rights. To secure rights, government, education and the fullest liberty of public opinion and public discussion are absolutely necessary. To use the words of one of his disciples translated by James Mill: "So absolutely necessary is it to leave the whole body of society the greatest possible freedom of examination and contradiction, so absolutely necessary is it to abandon evidence to its own strength, that there is no other power of what magnitude so ever, can command actions alone, never opinions. The experience of every day affords to this truth the evidence of our senses. So little have our physical powers any influence over our opinions that our opinions, on the contrary, exercise an uncontrollable dominion over our physical powers. Our physical powers are put in motion and guided by our opinions alone,"

Through education and full freedom of discussion we reach clear, defined views of rights and duties in social relations. These views should be expressed in definite written laws, which should contain the reasons for their existence.

“It is not, therefore, in the letter, but in the reason of the law that we must seek for the first principle of a constant submission and obedience to the laws.” The magistrates should be distinct from legislative authority. It should be their province to interpret laws, give the reasons for them, and propose new laws. He held they had absolutely no right to enforce bad laws. He held that legislative and executive functions together, and should be united in one person, an hereditary sovereign, that his interests would be identical with the interests of the whole people, that as a consequence the King would only make and enforce good laws. In this view we may find one reason why the King admired him. It is difficult in the light of history to harmonize this view with his other views. It is not strange that he has been charged with teaching democratic principles under a mask.

He then considered the revenues of government, and in discussing that problem, reduced for the first time economics or political economy to a scientific form. His theory was that agriculture, mining and fishing alone added to the gross product, and produced a surplus beyond the needs of the labor and capital employed. This surplus he called the *produit net*. Out of this net product all the classes, no matter how useful, must subsist. Manufacturers and traders only replace in manufacture and trade in another form the values they consume, except sometimes in foreign trade. Hence labor and capital should not be taxed, but the tax should be taken out of the net product of the land. Such a tax, he held, would be cheapest and best for the owners of landed estates, and gives the greatest freedom to all; that so long as it followed and did not exceed the net product, the prosperity of the state and of all would be sure.

The following extracts from Quesney’s “General Maxims for the Economic Government of an Agricultural Kingdom,” are taken from Blaquí’s “History of Political Economy.”

Let the tax not be destructive nor disproportioned to the total revenue of the nation; let its increase follow the increase of the revenue; let it be assessed directly on the net product of the landed property and not on the wages of men, nor on provisions, when it would multiply expenses of collection, be prejudicial to commerce and destroy annually a part of the wealth of the nation.

Neither let it be taken from the wealth of the farmers of landed property, for the advances of the agriculture of a kingdom must be looked upon as a fixed property which must be carefully preserved for the production of the impost, the revenue, and the subsistence of all classes of citizens; otherwise,

the tax degenerates into spoliation and causes a dwindling away which quickly ruins a state.

Let openings for the sale and transportation of the products of manual labor be facilitated by the repair of roads, and by navigation on the canals, rivers and seas; because the more that is saved in the expenses of commerce, the more the revenue of the territory is increased.

Let entire freedom of trade be maintained; for the regulation of the internal and foreign trade, which is the most secure, most exact, and the most profitable for a nation and a state, consists in full liberty of competition.

These maxims should be engraven deep in the mind of all.

His doctrine of the divine right of Kings and of the necessity of an autocratic government has been abandoned by French and English speaking people. His ideas of productive labor have been expanded to manufacture and commerce. With that expansion has come the development of the net product of farming and mining lands to the economic or ground rent of all lands.

His method of raising revenues, *l'impôt unique*, has been developed by such profound thinkers as James and John Stuart Mill, Thomas Chalmers, Henry George and others into the single tax upon land values, or economic rent. This tax is yet destined to be adopted as the ideal system of taxation, absolutely necessary to produce perfect freedom of human activity, the great end of all government.

Quesney died at Versailles, December, 1774, in his 80th year. Though he lived in the most corrupt court of Europe he held to the last the confidence and esteem of all who knew him, leaving a name untarnished by the breath of scandal.

His life is a grand and instructive lesson to all physicians. It shows how the physician, brought as he is, constantly in contact with the great struggle of man for bread, may become a tremendous power in bringing about a happier condition of affairs. Crime, insanity and other forms of disease are largely the result of that struggle, and to produce a social condition in which there shall be "freedom and justice in all social relations, freedom of conscience and freedom of the press, freedom of trade and commerce, equality before the law for every man," is to diminish disease and crime in all its forms.

It is just as much the province of the physician to show how to prevent disease as it is to cure it. If all physicians were to follow Quesnay's thought and example, they would be quickened and strengthened in every noble impulse and activity, and the medical fraternity would become one of the greatest forces in bringing about a just, social state, where disease would be rare and health and happiness abound.



## MORTUARY REPORT OF NEW ORLEANS.

FOR AUGUST, 1891.

CAUSE.	White	Colored	Male	Female	Adults	Children	Total
Fever, Yellow .....							
“ Malarial (unclassified) .....	9	7	10	6	10	6	16
“ Intermittent .....		1		1		1	1
“ Remittent .....	9	3	7	5	9	3	12
“ Congestive .....	9	3	5	7	10	2	12
“ Typho-Malarial .....	6	2	6	2	3	5	8
“ Typhoid or Enteric .....	6		2	4	4	2	6
“ Puerperal .....		3		3	3		3
Scarlatina .....							
Small-pox .....							
Measles .....							
Diphtheria .....	1			1		1	1
Whooping Cough .....	1	2		3		3	3
Meningitis .....	6	1	4	3	1	6	7
Pneumonia .....	7	6	7	6	10	3	13
Bronchitis .....	7	1	5	3	3	5	8
Consumption .....	39	28	31	36	64	3	67
Cancer .....	10	2	6	6	12		12
Congestion of Brain .....	12	3	12	3	9	6	15
Bright's Disease (Nephritis) .....	15	5	16	4	20		20
Diarrhœa (Enteritis) .....	18	6	13	11	12	12	24
Cholera Infantum .....	9	6	10	5		15	15
Dysentery .....	4		2	2	4		4
Debility, General .....	1	3	1	3	4		4
“ Senile .....	19	5	12	12	24		24
“ Infantile .....	4	3	4	3		7	7
All other causes .....	174	67	121	120	158	83	241
TOTAL .....	366	157	274	249	360	163	523

Still-born Children—White, 25; colored, 19; total, 44.

Population of City—White, 184,500; colored, 69,500; total, 254,000.

Death Rate per 1000 per annum for City—White, 24.89; colored, 27.11. total, 24.71.

HENRY WILLIAM BLANC, M. D.,

Chief Sanitary Inspector.

## METEOROLOGICAL SUMMARY—AUGUST.

STATION—NEW ORLEANS.

Date.....	TEMPERATURE.			Precipn. in inches and hundredths..	SUMMARY.
	Mean	Max..	Min..		
1	84	91	78	.31	Mean barometer, 30.047.
2	84	89	78	0	Highest barometer, 20.134, 16th.
3	80	82	78	.39	Lowest barometer, 29.897, 1st.
4	79	84	74	.04	Mean temperature, 81.2.
5	82	90	74	0	Highest temp., 93, 20th; lowest, 63, 24th.
6	84	91	76	0	Greatest daily range of temperature, 21, 7th.
7	80	91	70	.39	Least daily range of temperature, 4, 3rd.
8	81	87	75	.01	MEAN TEMPERATURE FOR THIS MONTH IN—
9	82	89	76	T	1871..... 82.8    1876..... 81.9    1881..... 82.8    1886..... 81.4
10	82	88	76	0	1872..... 82.5    1877..... 82.8    1882..... 80.5    1887..... 81.0
11	84	93	76	0	1873..... 81.0    1878..... 83.6    1883..... 83.3    1888..... 78.2
12	84	93	76	0	1874..... 83.8    1879..... 80.8    1884..... 82.3    1889..... 80.6
13	83	91	75	0	1875..... 79.1    1880..... 81.1    1885..... 80.4    1890..... 80.6
14	81	90	72	.10	1891..... 81.2
15	82	88	77	.09	Total deficiency in temp'ture during month, 11.
16	83	90	76	.01	Total deficiency in temp'ture since Jan. 1, 94.
17	84	91	76	T	Prevailing direction of wind, S. W.
18	84	90	78	T	Total movement of wind, 4837 miles.
19	84	91	78	.11	Extreme velocity of wind, direction, and date,
20	86	93	78	.02	32 miles, from S. E., 7th.
21	86	93	78	0	Total precipitation, 1.69 inches.
22	84	89	78	T	Number of days on which .01 inch or more of
23	77	81	73	.22	precipitation fell, 11.
24	71	79	63	0	TOTAL PRECIPITATION (IN INCHES AND HUNDREDTHS)
25	72	81	63	0	FOR THIS MONTH IN—
26	76	84	67	0	1871..... 7.21    1876..... 4.44    1881..... 4.21    1886..... 2.40
27	80	88	71	0	1872..... 3.75    1877..... 2.54    1882..... 9.47    1887..... 7.42
28	82	89	75	0	1873..... 8.30    1878..... 5.31    1883..... 4.12    1888..... 22.74
29	78	85	70	0	1874..... 4.82    1879..... 10.44    1884..... 0.87    1889..... 5.59
30	76	86	67	0	1875..... 8.61    1880..... 4.00    1885..... 4.25    1890..... 3.62
31	80	89	72	0	1891..... 1.69
					Total deficiency in precip'n during month, 4.51.
					Total deficiency in precip'n since Jan. 1, 19.90.
					Number of clear days, 7; partly cloudy days,
					19; cloudy days, 5.
					Dates of Frost, .....
					Mean maximum temperature, 88.3.
					Mean minimum temperature, 74.0.

NOTE.—Barometer reduced to sea level. The T indicates trace of precipitation.

G. E. HUNT, Local Forecast Official.

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New Orleans

Medical and Surgical

Journal.

Augustus McShane, M. D.,

Editor and Publisher.

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# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

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## Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the first day of the month preceding that in which they are expected to appear. A complimentary edition of twenty-five reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a *written* order for the same accompany the paper.]

### MULTIPLE LIGATURE OF VARICOSE VEINS OF THE LEGS.\*

By PHILIP BEEKMAN, M. D., NATCHEZ, MISS,

Late House Physician and Surgeon, St. Vincent's Hospital, New York.

The frequency of varicose veins of the legs; the annoying and painful conditions that travel in their wake; the actual danger to life attached; and the sparcity of publication in regard the best, speediest and easiest means of effecting a radical cure, are my reasons for introducing this subject.

The procedure of obstructing the flow of blood through varicose veins is by no means a recent innovation; however, many of the means heretofore in vogue were bunglesome, tedious, intensely painful, involved the dangers of infective emboli and pyæmia, and, above all, did not remedy the condition.

In order that we may more thoroughly grasp the subject and see more distinctly the rationale of the treatment I recommend, let us turn for a few moments to a consideration of the causation and pathology of the disorder itself, as well as the conditions dependent thereon.

Sedentary habits and prolonged standing favor gravitation of blood to the lower extremities, and the burden of this increased vascularity falls upon the superficial veins. Preg-

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\* Read before the Adams County Medical Society, Natchez, Miss.

nancy and abdominal tumors mechanically impede return of blood from the lower extremities.

The pernicious effect of tight garters must be included among the etiological factors. The superficial veins suffer while the deep ones escape, as the former are not supported by surrounding muscular tissues.

When the veins become sufficiently dilated the valves are rendered incompetent and the condition becomes aggravated—degenerative changes take place, and these vessels are no longer capable of fulfilling their physiological functions.

Varicose veins are elongated as well as increased in diameter, forming curves and bending back and forth on themselves. Sometimes the enlargements at particular points appear like multilocular fluctuating tumors, projecting beyond the level of the surrounding skin. The walls are thinned in proportion to the dilatation.

The diagnosis of the condition is so easy that it would appear a waste of time to mention the points upon which it is made. A mere glance is often sufficient to make the diagnosis.

The prognosis and effects produced by the varicose veins are what interest us even more than the condition itself.

Spontaneous cure seldom occurs, except the vessel become plugged by a coagulum and be thus obliterated. The main evils that result are due to faulty nutrition. The skin loses its elasticity and becomes pigmented in places, especially the lower third of the leg, and ulcerations or chronic eczema, or both, ensue.

Another accident is rupture of the varicose vein or one of its tributaries. This is usually brought about by the process of ulceration. The hemorrhage is often so profuse as to produce intense anæmia, and even death in a short time. Another accident is phlebitis, which may be followed by suppuration and embolism.

The indication for operative interference may be summarized as follows:

1. If the varix be so large as to produce inconvenience or pain.
2. If a vein have burst or is on the point of bursting.

3. If an ulcer or eczema depending on varicose veins refuses to heal.

4. If the person afflicted with varicose veins of the legs is an applicant for enlistment in the United States Army or on the police department of many of the large cities, where the existence of this disorder causes rejection.

Any procedure towards effecting a radical cure must have for its object the *total obliteration* of the *entire diseased vein or veins*.

It is obvious that obliteration at a single point would not accomplish this, as the free inosculation of the superficial veins would admit of circulation in the diseased vessel above and below the point of constriction, by virtue of their lateral branches. The vessels must be constricted at short intervals all along their course, if we wish to see any real and permanent results ensue. Therefore, from an anatomical standpoint, *single* ligature does not offer the slightest hope of permanent cure.

The question then might be pertinently raised, why, in multiple ligature, will not the blood collect in pockets between the ligatures (for inosculations take place at short intervals), and foil our efforts?

This objection can be most satisfactorily answered and brings out what I want most to impress.

When a vessel is ligated in its continuity clots are formed on both the distal and proximal side of the ligature, extending up and down the vessel for a variable distance. These are in the course of a short time organized, and clot and vessel converted into a fibrous cord. Now, when the ligatures are placed near enough to each other, the distal clot from the ligature above meets the proximal clot from the ligature next below, and thus the entire vessel between the two ligatures becomes obliterated. In this manner, from ligature to ligature the lumen of the vessel is destroyed, and it never again can become a conveyer of blood. I think this explains clearly to all the advantage of *multiple* ligature over the *single* ligature.

The idea of multiple ligature is by no means a new one, but the mode of applying them has been much improved and simplified.



The use of harelip pins by passing them beneath the vein and winding a figure-of-eight ligature over them, after placing a piece of a bougie over the vein to secure even pressure and prevent the silk from cutting, seems to have been recommended and used extensively, and no doubt with much success. However, there certainly must be considerable after-pain attending it, as the sensitive skin is included between the pin and the ligature; moreover, the presence of the pins (partially buried and partially exposed), the bougies and the silk enhances the risk of infection.

The plan I wish to submit to your consideration is the one pursued by Dr. Chas. Phelps, of New York, who I think is the originator of the operation, and to whom I am indebted for personal instructions in the technique thereof. The material used for ligature is catgut, and the number of ligatures introduced varies according to the extent of involvement. Sometimes five or six will suffice, while in other cases as many as thirty in a single leg may be required.

The manner of applying the ligatures is by the subcutaneous method, and no trace is left on the surface save the punctures produced by the entrance and exit of the needle.

The needle which I prefer is the straight varicocele needle devised by Dr. E. L. Keyes, of New York, though an ordinary straight surgical needle can be made to fulfil the purpose.

The Keyes needle is so constructed that the eye, which is near the puncturing end, is opened and closed by a slide. This does away with the tediousness of threading.

The catgut should be small enough to allow the knot to pass through the opening in the skin produced by the needle; however, there is no serious objection to the knot remaining on the outside except that perhaps the pain may be a trifle more than when it sinks below.

In tying, the friction knot, made by passing the end twice around the loop, instead of once, is preferable, as it does away with the risk of slipping.

The pain of the operation is not severe, and when only a few ligatures are to be applied it may be done without an anæsthetic, the patient standing upon the table throughout,

thus favoring the gravitation of the blood, making the veins plainly visible.

When an anæsthetic is to be given an elastic bandage is placed around the thigh with the patient standing; the leg is rendered aseptic, and as soon as the veins become engorged the points selected for ligature are marked by dots on either side of the vein made with nitric acid or tincture of iodine on the point of a sharpened stick. The acid is preferable, as the marks are not erased by subsequent irrigation.

The limb is then wrapped in towels wrung out of a bichloride solution (1-1000); the patient assumes the recumbent posture, and the anæsthetic administered.

The ligatures are introduced as follows: The selected vein with its surrounding skin is picked up between the thumb and forefinger, and the needle (armed with a ligature) introduced through the skin on one side passing *under* the vein, and making exit on the other side. The eye of the needle is then opened and the ligature detached; the eye is closed again and the needle withdrawn.

We now have a ligature passing from the point of entrance to the point of exit *under* the vein. The needle is now reintroduced (unarmed) into the same opening produced by the former puncture, and made to pass *above* the vein—*i. e.*, between the vein and integument, making exit at the point of exit produced by the first puncture.

The eye is now opened, the ligature introduced into it, the eye closed and the needle withdrawn.

We now have the ligature around the veins and both ends making exit from the same opening. All that remains to be done is to tie as above described.

The ligatures should be placed within three to five inches of each other. When veins bend back and forth upon themselves, forming masses, be sure to tie all trunks above and below, and, if possible, ligate individual vessels within the mass.

Sometimes collateral branches are punctured; it matters naught except the annoyance of slight bleeding.

Avoid applying ligatures at points where large collateral branches are given off—rather tie the individual veins an inch

or so from the point of union. Avoid tying over bony prominences.

The entire operation should be conducted under antiseptic precautions.

Where an ulcer exists it should be thoroughly cleansed and kept covered with aseptic towels during the entire operation to prevent infection of the new wounds. In some severe cases I have found it advisable to apply one or two ligatures to the internal saphenous above the bend of the knee.

The parts should be dressed antiseptically, and where many ligatures have been applied, it is best to add a posterior splint extending above the knee to insure perfect rest.

The dressings need not be disturbed for a week or ten days, provided there be no rise of temperature. At the end of this time the wounds are usually perfectly healed. Occasionally one or two points of suppuration will occur. They never amount to more than small stitch abscesses that heal promptly after evacuation. It is extra precaution to keep the limb bandaged until the clots within the veins become organized.

The operation is applicable to all ages. One patient, in which I assisted Dr. Phelps, was seventy years of age. She made an uninterrupted recovery.

I am unable to say much about the permanency of the cure as far as my own cases are concerned, as they have not as yet had the opportunity of standing the test of time; however, Dr. Phelps reported a number of cases that had at the end of several years shown no sign of return.

The points I urge in favor of this operation are, ease of performance, little or no after-pain, freedom from danger, permanency of results.

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#### MALARIAL HÆMATURIA.

By JOHN W. MEEK, M. D., CAMDEN, ARKANSAS.

As several articles have appeared in the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL on the above named disease, within the past few months, I will add my experience to the



literature of this subject. If one will search the literature of this subject, as published by the journals of the south (our textbook authors have not yet found out that there is such a malady), he will be convinced that "experience does not teach all men alike." In the hands of some, quinine is the panacea—with others, it is a *poison*. My experience, meeting with an occasional case for twenty-five years, forces me to record myself with those who believe it, in this malady, to be a *poison*. As I have met it, the following have been its accompaniments: It invariably occurs in one suffering from malarial cachexia, usually of an intermittent type. The patient has a chill of no unusual severity: the fever is not excessive, but is accompanied by pains of unusual severity in loins and stomach. Usually at the end of cold stage the patient passes a large quantity of bloody urine, and in six hours or less he is completely jaundiced. Rigors, followed by rise of temperature, frequently recur every six hours. There is usually excessive nausea, and bowels are constipated. Of course the jaundice is of hæmatogenous origin. Ligation of the common duct could not so quickly jaundice the entire body. The vital fluid is being acted on by some subtle but potent agent that is disintegrating the red corpuscles and rendering them unfit to sustain life, and what we want is some agent that will arrest this retrograde metamorphosis, and at the same time "cleanse the system of that perilous stuff" that is poisoning all the organs necessary to life.

So completely is the blood devitalized that it sometimes oozes from the gums—in the latter stage is vomited as "black vomit," and in one of my cases, when a blister was placed over epigastrium, it filled with bloody serum.

As this disease occurs in malarial regions and in malarious subjects, we have naturally looked for benefit from quinine, but I have looked in vain. For the first ten years of my professional life I was zealously advocating and giving quinine to these cases, but always attended by a mortality of fully 50 per cent.

For the last ten years I have given no quinine, and have reduced the mortality to 25 per cent.

The treatment that I have followed (and it certainly is not

new nor original with me) is hyposulphite of sodium in large doses, with such other adjuncts as the symptoms may demand.

Quinine will not arrest the paroxysms, and at the same time it depresses the heart, in large doses, and completely upsets the stomach, rendering it utterly intolerant of anything. I have given it by mouth, rectum and hypodermically, and always with the same result. I have given it in 40, 60 and 80-grain allowances each day, and still without any other effect than to damage the patient's chances for recovery.

Why quinine will cure nearly all other forms of malaria but this, I will not attempt to explain, and why hyposulphite of sodium will cure many cases of malarial hæmaturia and be worthless in the ordinary manifestations of malaria is a hidden mystery. I am convinced that it will do it, in the majority of cases, and I am ready to say, "Let the miracle be done though Mahomet do it." The explanation that I will offer is that hyposulphurous acid is liberated in the blood and checks the process of devitalization that is going on there, and at the same time the hyposulphite acts as a cholagogue cathartic and thus assists in eliminating the poisonous accumulations by way of the liver and intestines.

The treatment that I would recommend then is as follows :

1. Give hyposulphite of sodium in drachm doses every two hours until patient is freely purged, and then given in smaller doses until the entire body is saturated with it.

2. Give morphia and atropia hypodermically to quiet the stomach, and to these add a blister over the epigastrium if necessary.

3. Give an abundance of water to work out the coagula that must necessarily accumulate in the urinary tubules after a hæmorrhage. Hot water or hot lemonade is frequently better borne by the stomach than cold. Cupping over loins is also to be recommended.

4. The diet should be unstimulating. Fresh buttermilk is usually well borne and is also a mild diuretic, and I have come to rely on it as an article of food in this as in many other diseases.

5. The patient should, if possible, be kept strictly in a recumbent posture. This treatment, as far as I know, origi-

nated with Dr. Wm. Wright, an old and able country practitioner, of Union Co., Arkansas (peace to his ashes!), and was communicated to me more than twenty years ago, but so strong was my faith in the indications for quinine that for years I feared to adopt it, and I was only forced to try it by my repeated failures with the latter remedy.

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PORTUGUESE SURGERY AT THE COMMENCEMENT OF THE  
LAST CENTURY, WITH A FEW REMARKS ON THE  
MIRACLES OF OUR AGE.

BY DR. JOHN DELL'ORTO, NEW ORLEANS, LA.

In *A Medicina Contemporanea* of Lisbon, Dr. A. L. Peres writes a very curious and interesting article on two surgical operations performed in Portugal at the commencement of the last century, which are really worthy of notice in our journal, as a valuable contribution on medical literature.

The first is a case of laparotomy for the extraction of a foetus, who died from the effects of traumatism suffered by the mother. The operation was performed in 1733 by Surgeon Francisco Correia do Amaral e Castello Branco.

The following is the history, which we will try to translate as literally and faithfully as possible:

Theresa Maria was the name of the patient. She was the wife of Joa da Silva, a shoemaker, and a mother of eight children. On the fourth day of March, 1733, while pregnant, and within a few days of term, she fell on her abdomen. Pains resembling those of labor soon appeared. But in spite of all the medicines administered during one month the foetus could not be brought out through the natural ways.

Meantime, the assistant surgeon declared that in order to soften the walls of the abdomen he applied a plaster of *magnetic virtues*. The plaster had its effect. On the 21st of April the umbilical region grew really softer. It looked like an abscess with small openings all around. He dilated these openings with a large incision, and then with *proper instru-*



ments he separated the muscles, taking care not to injure the guts, and finally he extracted a large fœtus in a complete state of putrefaction. After having cut off some mortified tissues, and *prevented the air from penetrating into the abdominal cavity* (how he did it, it is not reported), he *fomented* the cavity with a *remedy of his own invention*.

The paper does not say anything about suturing the wound, it only says that the cavity soon filled up with healthy granulations (*casi toda encarnada e com materias laudaveis*) and that thirty-seven days after the operation, the wound was almost healed, and a few days later the woman was perfectly well. The following quotation is very curious:

“The family of this patient,” says Surgeon Coireia, candidly “was extremely poor, and perhaps it was a good luck “for her to be poor. Had she been a lady of rank and riches “there would have been more confusion and uncertainty in “the treatment, and probably more danger. And this is the “reason why a writer of medicine said: ‘It is not in palaces, “that the best cures are obtained.’”

Dr. Lopes seems to be of the opinion that this was a case of abdominal or extra-uterine pregnancy. We are rather inclined to believe in a laceration of the womb, through which the fœtus passed. But this laceration must have taken place slowly and gradually, otherwise the woman would have died long time before any surgical interference. During that long period of more than forty days before the operation, the providential nature, through its mysterious *vis medicatrix* had most probably caused healthy adhesions around the cavity from which, immediately after the extraction of the fœtus, those granulations started that so rapidly closed the womb, and saved the life of the patient.

The report of the second case is extracted from a pamphlet of forty pages, published in 1735, under the title: *A surgical observation. A case not only rare but unique of a bony hernia, casually discovered, courageously extracted and happily cured by Lorenzo Pereira da Rocha, ordinary surgeon of His Majesty, whom God may help, in the city of Lamego, offered to the curious, but more especially to physicians, surgeons, anatomists, naturalists, and politicians.*

This publication, Dr. Lopes says, is a very learned one, and contains many quotations from Latin and Portuguese authors, even from Camoens. The subject of the case was a carpenter, thirty-two years of age, and a father of five children. In the month of May, 1734, Dr. Lourenço da Rocha saw him for the first time. Seven years before the patient noticed a small swelling on the left side of the scrotum, near his left groin. The swelling soon became very hard, but painless, and gradually increased to such a proportion that he was obliged to send for the surgeon. The tumor occupied the whole scrotum, extending way up the pubis, and measuring four and one-half spans (*palmos*) in circumference, and two and one-half in length. It looked like a promontory, and was as hard as a rock.

After an accurate examination, the surgeon called the tumor a fleshy hernia. (We may call this a *priori* diagnosis.)

He commenced the treatment with the use of mercurial ointment for syphilitic taint—*qualidade gallica*. No good result was obtained. Finally, seeing that the tumor was going to be mortified, and feeling some tender spots with fluctuation, surgical interference was determined upon.

On the 6th of November, 1734, a puncture was made. Nothing but some flatus came out—*um furacão de vento*. Very high fever followed the puncture, accompanied by severe pains in the abdomen, suppression of urine, etc.

A few days afterward, Dr. Pereira, encouraged by the advices of Hippocrates, trusting on the holy Virgin Mary—*fiado na protecção de Maria Santissima*—and with the assistance of his colleague, Lourenço da Ponte Rebeiro, and several others, made a very long incision, which enabled him to extract a big bone having the shape of *the skull of a mutton's head*, together with other smaller ones. There was a profuse hæmorrhage. In view of the aggravated condition of the patient, the operation was continued next day, when he removed a very large mass of schirrous matter, and a few little bones more. Then he discovered the peritoneum and removed the left testicle, which was in a state of *sphacellus*.

As in the other case, there was no suturing; the incision

was left open to heal by granulations. After a few days of very serious symptoms the patient had a good recovery.

Twenty-six bones were extracted—therefore the operator called the tumor a *bony hernia, caused by the stagnation of seminal matter in consequence of protracted abstinence from sexual intercourse.*

Here ends the history of this extraordinary case.

In concluding his article, Dr. Lopes eulogizes the skill of the operator, and attributes to him the honor of having discovered for the first time a clinical feature, which was in our days classically described by Velpeau under the name of scrotal inclosure.

When we think of the miracles accomplished by modern surgery with the ample materials and improvements that science and industry places at our command, and compare them to the surgery of past ages, in times of widespread superstition, when anæsthesia, asepsis, antisepsis, and even cleanliness were unknown, we have to admire the calm, the boldness and the skill of those surgeons, and to be astonished at the miraculous results they could secure in their operations. We must not laugh at them when they speak of remedies of their own invention endowed with *magnetic virtues*: we must not ridicule the gentleman who dedicates his medical works to politicians and invokes the protection of the Holy Virgin while performing an operation, because we men of the nineteenth century are no better than they were.

We have our patent magnetic and eclectic medicines, good for all diseases. The politician doctor is a specialty of our times. Bigotry, quackery, fanaticism, both political and religious, have still a strong hold on the minds of many people. The recent pilgrimage to Treves, in Germany, in *docta Germania*, where more than 2,000,000 of persons went to be cured by the healing virtues of the holy coat, is the best testimony of the truth of our assertion.

It seems that there was some excitement in Europe about that coat. According to an old tradition the honor of possessing the genuine coat of Jesus Christ belongs to the town of Argenteuil, in France, just as the Benedictine monks of Charroux



used to have, several hundred years ago, a *reliquaire* supposed to contain his prepuce.

A humorous Italian paper, which we have just received, says that the faithful have settled the matter by compromise. It was decided that Jesus Christ must have had two suits—one for the week days and the other for the Sabbath. So everybody was satisfied, and we are very glad of it. There will be no war in Europe.

#### CANNABIS INDICA AS AN ANODYNE AND HYPNOTIC.\*

By J. B. MATTISON, M. D.

Medical Director Brooklyn Home for Habitues; member American Medical Association; American Association for the Cure of Inebriety; New York Academy of Medicine; New York Med.-Leg. Society; New York Neurological Society; Medical Society of the County of Kings.

Indian hemp is not a poison. This statement is made, just here, because the writer thinks a fear of its toxic power is one reason why this drug is not more largely used. This mistaken idea lessens its value, because it is not pushed to the point of securing a full therapeutic effect. This is a fact. One of the best pharmacologists in this country not long since expressed a very touching solicitude lest the writer's advocating robust doses of this valued drug might cause a decrease in the census that would seriously imperil his professional good repute.

There is not on record any well-attested case of death from *cannabis indica*. Potter says: "Death has never been produced." Hare asserts: "No case of death from its use in man is on record." Bartholow affirms: "Cases of acute poisoning have never been reported." Stillé states: "We are not acquainted with any instance of death." Wood declares: "Hemp is not a dangerous drug; even the largest doses do not compromise life. No acute fatal poisoning has been reported." A prolonged personal experience, compassing the history of many cases—men and women—and hundreds of doses, ranging from 30 to 60 minims of the fluid extract, has never brought any anxiety along toxic lines.

\*Read before the Medical Society of the County of Kings, September 15, 1891.

Having thus brushed aside this bugbear, we may note, *en passant*, the statement, on high authority—Potter—that “cannabis was formerly much employed as an anodyne and hypnotic. It is now somewhat out of fashion.” Why this early repute has not been continued, is due to a cause cited, coupled with non-reliable products, and, doubtless, the coming of other analgesic-soporifics. The first cause need not longer obtain; the second can be removed by careful choosing and trial; while the last should not preclude the use of a drug that has a special value in some morbid conditions, and the intrinsic merit and superior safety of which entitle it to the place it once held in therapeutics. Digitalis, for a time, was in disuse. So, too, codeine, which my experience has proved a valued anodyne—one worthy a wider use than it has had, and which I think it will surely get—and impelled me to present the American Medical Association, at its last meeting, with a paper thereon, that I trust you have done me the honor to read.

There is a consensus of opinion among writers on therapeutics as to the anti-agrypnic, analgesic and anæsthetic power of Indian hemp. For the latter it was used prior to ether. Wood, testing it in himself, asserted “marked anæsthesia of the skin all day.” Stillé says: “Its anæsthetic virtue is shown in allaying the intense itching of eczema, so as to permit sleep.” And that a similar seemingly-trivial disorder may have a serious outcome is proven by the fact that a well-marked case of triple addiction, under my care last year—a medical man who took daily 15 grains morphine with 35 grains cocaine, subcutaneously, and 14 ounces of rum—had its rise in a morphia hypodermic taken to relieve urticaria.

Stillé says: “Its curative powers are unquestionable in spasmodic and painful affections.” Noting the latter in detail, its most important use is in that opprobrium of the healing art—migraine. In a paper by the writer, eight years ago, “Opium Addiction among Medical Men,”—*Medical Record*, June 9, 1883—in reviewing the causes, this was asserted the most frequent. Enlarged experience has not changed that opinion. A case from such cause, woman, ten years morphia taking, 30 grains, by mouth, daily, is now under my care. A

sister, so situated from the same cause, awaits similar service; and her mother took morphia for headache till death ended her need.

Ringer says: "No single drug have I found so useful in migraine." He thinks it acts well in all forms, but seems most useful in preventing rather than arresting. He deems it specially effective in attacks due to fatigue, anxiety, or climacteric change. Dr. E. C. Seguin, in 1877, commended it highly.

Dr. Wharton Sinkler, in a paper on migraine, gives first place to cannabis, and thinks it of more value in this form of headache than any other. Richard Green, who first commended it in this complaint, thinks it not only relieves but cures; in nearly all cases giving lasting relief.

In the *British Medical Journal*, July 4, 1891, Dr. Suckling, Professor of Medicine, Queen's College, Birmingham, writes: "I have during the last few years been accustomed to prescribe Indian hemp in many conditions, and this drug seems to me to deserve a better repute than it has obtained." He calls it "almost a specific" in a form of insanity peculiar to women, caused by mental worry or moral shock, in which it clearly acts as a psychic anodyne—"seems to remove the mental distress and unrest." After commending it in melancholia and mania, he says: "In migraine the drug is of great value; a pill containing one-half grain of the extract, with or without one-quarter grain of phosphate of zinc, will often immediately check an attack, and if the pill be given twice a day continuously, the severity and frequency of the attacks are often much diminished. I have met with patients who have been incapacitated for work from the frequency of the attacks, and who have been enabled by use of Indian hemp to resume their employment." In a personal note from the doctor he wrote: "I have used Indian hemp as an anodyne and hypnotic, and find it most useful in both ways. I have never seen any ill results."

Anstie commends it in the migraine and the pains of chronic chloral and alcohol taking. In his work on neuralgia—the best ever written, and one which I advise every one to read, if not read—he says: "From one quarter to one-half grain of *good*



*extract of cannabis, repeated in two hours, if it has not produced sleep, is an excellent remedy in migraine of the young. It is very important in this disease that the habit of long neuralgic paroxysms should not be set up.*”

Russell Reynolds thinks that in neuralgia, migraine and neuritis, even of long standing, it is by far the best of drugs. Mackenzie has used it with success in constant all-day headache, not dependent on anæmia or peripheral irritation. Bastian and Reynolds commend it in the delirium of cerebral softening, and the latter says it calms the head pain and unrest of epileptics. In cardiac tumult, in senile insomnia and delirium, and the night unrest of general paresis it acts well.

In some diseases common to women hemp works well. Grailly Hewitt says that in many cases of uterine cancer it allays or prevents pain. Ringer asserts it sometimes signally useful in dysmenorrhœa. West commends it here. Potter states that its anodyne power is marked in chronic metritis and dysmenorrhœa; and Hare thinks it of great value in chronic uterine irritation and nervous and spasmodic dysmenorrhœa. Donovan and Fuller claim it of value in migraine and chronic rheumatism; and Mackenzie in hay fever and hay asthma.

In genito-urinary disorder it often acts kindly—the renal pain of Bright’s disease; in vesical spasm; retention of urine, and chordee; and it calms the pain of clap equal to sandal or copaiva, and is less unpleasant. The distress of gastric ulcer and gastrodynia are eased by it, and in other and varied neuralgias it serves one well. In some cases of advanced phthisis and other cureless disease it will bring euthanasia by allaying pain and unrest.

My experience with hemp covers more than a decade, many cases, and several pounds of fluid extract. It is proper to state that these cases have been solely habitués or ex-habitués of opium, chloral or cocaine. In these, often, it has proved an efficient substitute for the poppy. Its power in this regard has sometimes surprised me. Both sexes took it, and with some no other drug anodyne was used. One of these—a naval surgeon, nine years a 10 grains daily subcutaneous morphia taker—recovered with less than a dozen doses. My oldest female patient—64—found its service complete. Its action has

varied, as some cases respond more fully. This during the early abstinence time. Later, it has done good in the post-poppy neuralgia, especially the cranial kind, and it has calmed mental pain and unrest.

As a hypnotic, Frommuller gave hemp in 1000 cases. Success, 530; partial success, 215; no success, 253. As such in delirium tremens, Potter declares it "the best." Anstie thought it better than opium when the pulse is feeble. Phillips asserts it "one of the most useful." Tyrrell and Beddoe say the same. Suckling's opinion has been given. McConnell commends it in the insomnia of chronic cardiac and renal disease. Oxley lauds it in the insomnia of severe chorea, especially in children; the tincture "more effectual than any other hypnotic."

My own results prove it a satisfactory soporific, even oftener than as an anodyne. And this, too, under conditions that test thoroughly the power of any drug in this regard, for the insomnia of ex-poppy habitués finds its equal only in the agrypnia of the insane. With many, no other hypnotic was used. The sleep has been sound and refreshing. Many cases showed a notable influence to it as regards time—somewhat akin to sulfonal. Two hours sufficed. The first, pleasant stimulation; the second, increasing drowsiness, ending in sleep.

Again, I admit my special cases may involve a condition making them more easily subject to hemp hypnosis, but these do not preclude the wisdom of its trial with other patients in whom it may act equally well.

Writers on cannabis refer to certain peculiar effects—which, in our thinking, are more often peculiar to the patient—that may here be noted. One is a mild intoxication. I say "mild," because the hashish, assassin-like, running-a-muck form is less fact than fancy. It is said temperament largely determines the mental effect, whether it be grave or gay, merry or mad. Most of my cases—when such—have been in a merry mood. Of the hundreds of times given, only once did it excite to violence. That was a young physician, six years ago, in which it came close to a personal assault on the writer that was warded off only by superior strength. The patient afterward avowed no knowledge of such situation, was profuse in

apology, and stated at once, after taking hemp simply to note results, he routed every one out of the house, including his own grandmother!

Catalepsy is a rare sequence. We have seen it once. A woman, 23, brunette, small but active, took, in early evening, 40 minims Squibb's fluid extract as a soporic. After playing cards half an hour, she began to be very jolly, and it was suggested she retire. Visiting her later, she was found completely cataleptic. It soon subsided, sleep followed, and no after ill effect.

Failure with hemp is largely due to inferior preparations, and this has had much to do with its limited use. It should never be called inert till full trial with an active product proves it.

Wood thinks the English extracts best. I have used, mainly, Squibb's fluid extract. To a small extent, Parke, Davis & Co.'s Normal Liquid. They are reliable. Hare commends the solid extract made by the latter, and by McKesson & Robbins.

Merck has produced two elegant and efficient extracts—cannabine tannate and cannabinone. They are essentially hypnotic. I show you specimens. The former has been found by Prior, Vogelsgesang, Mendel and others, a satisfactory soporific. Prior gave it one hundred times to thirty-five persons—the most with success. In hysteric cases not calmed by chloral or opium, it acts specially well. In the small dose of one grain it has brought sleep when one-third grain morphia failed.

Another cause of failure is too timid giving. I am convinced that the dose of books is often too small. The only true way is, once a good extract, push it to good effect. My doses have been large—40 to 60 minims of the fluid extract—overlarge for the narcotic habitués; but, as we years ago asserted, habitual poppy taking begets a peculiar tolerance of other nervines, and they must be more robustly given. Both sexes have taken them—women frequently—with no other effect than quiet and sleep. I think, for many, small doses are stimulant and exciting; large ones, sedative and quieting. They are the outcome of an experience with smaller doses that failed of effect desired. They prove hemp harmless, and



they add proof to the opinion of most neurologists that, once a nervine needed, it is often better to give one full dose than several small.

The tincture—3 grains to the drachm—may be given in doses of 20 to 60 minims. The fluid extract 5 to 20 minims. The solid extract  $\frac{1}{2}$  to 2 grains. Tannate of cannabin, 5 to 15 grains. Cannabinone,  $\frac{1}{2}$  to  $1\frac{1}{2}$  grains. Cannabinone with milk sugar, 5 to 15 grains, and each repeated or increased till a full effect is secured. It is said that in women cannabinone acts twice as strongly as in men. In headache, periodical or long continued,  $\frac{1}{2}$  to 2 grains solid extract may be given each hour or two till the attack is arrested, and then continued in a similar dose, morning and night, for weeks and months. It is important not to quit the drug during a respite from pain.

I close this paper by again asking attention to the need of giving hemp in migraine. Were its use limited to this alone, its worth, direct and indirect, would be greater than most imagine. Bear in mind the bane of American women is headache. Recollect that hemp eases pain without disturbing stomach and secretions so often as opium, and that competent men think it not only calmative, but curative. Above all, remember the close genetic relation of migraine relieved by opium to a disease that spares neither sex, state nor condition.

Dr. Suckling wrote me: "The young men rarely prescribe it." To them I specially commend it. With a wish for speedy effect, it is so easy to use that modern mischief-maker, hypodermic morphia, that they are prone to forget remote results of incautious opiate giving.

Would that the wisdom which has come to their professional fathers through, it may be, a hapless experience, might serve them to steer clear of narcotic shoals on which many a patient has gone awreck.

Indian hemp is not here lauded as a specific. It will, at times, fail. So do other drugs. But the many cases in which it acts well entitle it to a large and lasting confidence.

My experience warrants this statement: *cannabis indica* is often a safe and successful anodyne and hypnotic.

## Correspondence.

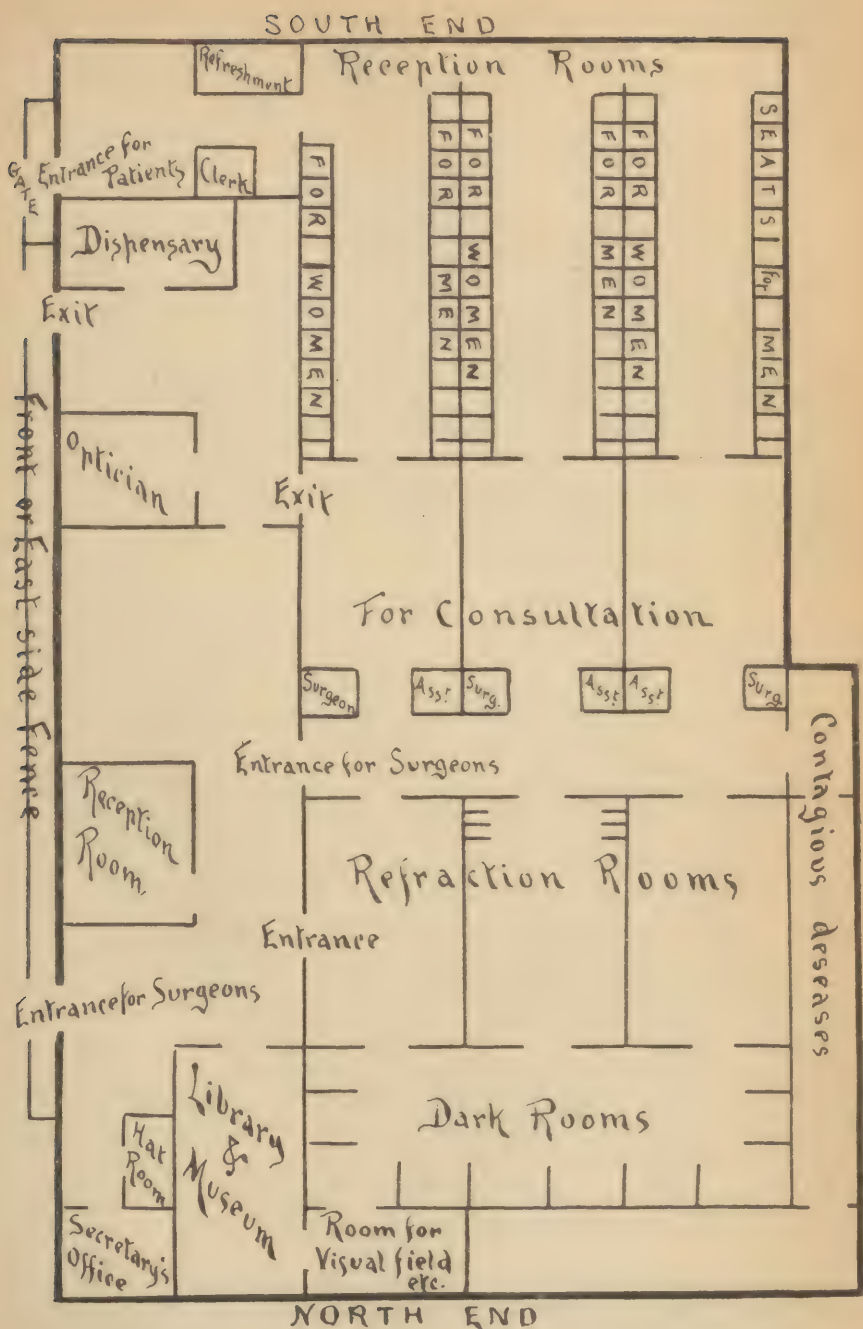
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[The following letter from Dr. C. A. Thigpen to Dr. A. W. de Roaldes is deemed of sufficient interest to our readers to merit publication. We are under obligations to both of these gentlemen for the privilege of publishing this interesting communication.—EDITOR.]

LONDON, ENG., October, 1891.

*Dr. A. W. de Roaldes, New Orleans:* DEAR DOCTOR—  
I have often thought that I would write you a letter, and I know of no occasion more suitable than the present one, nor can I find a subject of more interest to you, I believe, than European hospitals, knowing your great sympathy for institutions of this kind, and the much time and labor you have given in their behalf. It is not my purpose to take up each hospital as to its time and importance, for but a brief resumé of them all would afford material for volumes and be but tiresome to read. I shall therefore confine myself to some of the more important special ones in which I am at present most interested, and with the plans and workings of which I am more familiar. I shall begin, then, with Ophthalmic Hospitals, and among these I shall take first, The Royal London Ophthalmic Hospital, commonly known as Moorfields. It is situated north of the center of the city, in one of its busiest portions, is of easy access from all parts. It fronts to the east, is about 125 feet north to south, and 75 feet east to west. It is the largest and one of the oldest special eye hospitals in the world, and while it does not possess the advantages of most modern architecture, yet with its improvements and additions, it affords comforts and conveniences second to none. It is divided into four floors besides its basement, which is solely for kitchen and sundry purposes.

By reference to the enclosed sketch, which, by the way, is quite artless, you may be able to see how the first floor is divided. Viewing the eastern side, you will observe two gateways, one to the left marked for patients, the other to the right for surgeons and visitors. On entering this gate to the left, patients are directed by a notice over a doorway "entrance." Through this they pass to the clerk's office, where the names, etc., are taken, then they are provided with a card and a book, which admits them to the reception room. This room has three divisions, corresponding to the three surgeons in charge for each day. Each of these divisions has separate seats for



ROYAL OPHTHALMIC HOSPITAL, LONDON.—GROUND FLOOR.



men and for women. The reception room opens into the consultation room, which again has three divisions; at the end of each are two desks for the surgeon and his assistant. Adjoining the consultation room is a room for the treatment of contagious diseases, such cases as ophthalmia neonatorum and gonorrhoea, trachoma, etc. Just behind the desks are three rooms for refraction cases. These lead into the dark room for ophthalmoscopic examination, and adjoining these is a special apartment for taking the visual field and testing color perception. All patients, on leaving, are required to pass out by a different route from which they came; this leads through the optical and dispensing departments, where each one must have his prescription prepared. For such he is required to pay according to his means, but if such is lacking on account of poverty, his glasses or medicines are cheerfully given him.

On this same floor are the library and museum. This requires more than a passing notice, for here you find the finest and most select library of all times and all languages, pertaining to ophthalmology, and never could the mind conceive of a more beautiful or valuable collection of eyes than are therein displayed. The second floor is divided into the operating theatre, centrally situated, pathological laboratory, and wards for patients upon whom operations have been performed. The third and fourth floors are likewise divided into special wards for special diseases. Each floor has a selected ward for contagious diseases. There are one hundred beds.

The hospital is supported mainly by voluntary contributions, although a certain fee is exacted of those who can afford to pay anything. I suppose it will be an interesting fact to you to know that charities are as badly abused in England as in America, and no "well laid schemes or plans" have sufficed to prevent such abuses for these many years. The medical and surgical staff of this hospital is composed of some of the brightest minds in the world's history of medical science. Each one goes into his work, not only with the object of charity in view, but for making those observations and compiling those statistics which form the basis of the science of to-day. Toward such an end much time and care are taken in obtaining complete histories and noting accurately changes from day to day.

#### STAFF.

Consulting Physician: Stephen McKenzie, M. D.,  
F. R. C. P.

Consulting Surgeons: James Dixon, Esq.; Sir Wm.  
Bowman, Bart., F. R. S.; Jonathan Hutchinson, F. R. S.

Visiting Surgeons: Messrs. John Cowper, Warren Tay,

John Tweedy, E. Nettleship, R. Marcus Gunn, W. Lang, A. Q. Silcock, J. B. Lawford, A. Stanford Morton.

Pathologist: E. Treacher Collins.

Besides the visiting staff, there is the house surgeon and his assistant,

Each surgeon attends twice a week, making three surgeons daily.

After a surgeon shall have become three score years (sixty), he is required to resign. He then becomes honorary.

The clinics are held daily, patients being admitted from 8 to 10 A. M. After such time none are admitted, save those of cases of emergency. The daily attendance ranges from three to five hundred. During the last year the total number of our patients was 26,868. The total number of attendances, 129,325. Total number of in-patients was 1890. Of this number 1443 required surgical operations.

The hospital is well supplied with skilful nurses, having a matron and eight trained nurses, who have had previously to entering the hospitals a course of three years' training and experience in general hospitals. And these nurses are assigned to wards of special diseases, respectively.

The classes of diseases here are about the same as those in America. Some of the diseases, however, are more obstinate to treat than those of the southern climate; for instance, iritis requires a much longer time to run its course here than in New Orleans. Corneal ulcers are very stubborn, and I might mention here that the main reliance in their treatment is placed upon the cautery.

Trachoma or granular conjunctivitis, fortunately, is not so common in this densely populated city as in America, especially New York.

All operations are performed by the surgeons in charge, beginning at 10 o'clock daily, there being three different operators for each day. The cases of refractive errors are attended by the clinical assistants; these are students from all parts of the world who visit London for study, and each one by the payment of \$15 becomes officially a clinical assistant, and as such enjoys privileges and advantages for practical work excelled by none. I may say that any one who takes such a course at Moorfield is expected to know something of ophthalmology before he comes, otherwise he is at a great disadvantage, as no regular, systematic course of instruction is given.

The refraction is done by different methods, viz., by the direct method of ophthalmoscopy, retinoscopy or the shadow test, and lastly and the most reliable, by the test case. Mydri-

atics are always used in high degrees, and where any astigmatism exists. No stress is put upon muscular insufficiencies, as these are but the effects of cause, errors of refraction.

Besides all this, the student has an unlimited field for study of intra-ocular or fundus diseases. Out of such a great number of patients, every variety of inflammation and neoplasm is met with; and what is more important, such an excellent opportunity exists for the study of pathology, both macroscopical and microscopical. There is never an end to material.

As to the treatment of the various external diseases, nothing of note, aside from the general routine we have in America; besides procedures instituted by American ophthalmologists are frequently adopted here, and particularly Dr. Noyes' treatment for trachoma by expression of the follicles with forceps. But I see I have already gone beyond the bounds of a friendly communication, so I will reserve what else I have to write for another time. Very sincerely,

C. A. THIGPEN.

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## Proceedings of Societies.

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### SOUTHERN SURGICAL AND GYNECOLOGICAL SOCIETY.

Preliminary programme of the session of the Southern Surgical and Gynecological Association, to be held in Richmond, Va., November 10, 11 and 12, 1891.

President, Louis S. McMurtry, M. D., Louisville, Kentucky; Vice President, James McFadden Gaston, M. D., Atlanta, Georgia, and J. T. Wilson, M. D., Sherman, Texas; Secretary, W. E. B. Davis, M. D., Birmingham, Alabama; Treasurer, Hardin P. Cochrane, Birmingham, Alabama. Judicial Council: John S. Cain, M. D., Nashville, Tennessee; W. T. Briggs, M. D., Nashville, Tennessee; Virgil O. Hardon, M. D., Atlanta, Georgia; Bedford Brown, M. D., Alexandria, Virginia; George J. Englemann, M. D., St. Louis, Missouri. Chairman of the Committee of Arrangements, Hunter McGuire, M. D., Richmond, Virginia.



## PAPERS TO BE READ.

*(Partial List.)*

The President's Annual Address, Louis S. McMurtry, M. D., St. Louis, Mo.

Remarks on Systemic Infection from Gonorrhœa, Illustrated by Cases, Bedford Brown, M. D., Alexandria, Va.

The Rational Treatment of Peritonitis Based upon the Consideration of the Pathological Conditions Present, W. D. Haggard, M. D., Nashville, Tenn.

A Medico-Legal Aspect of Pelvic Inflammation, W. W. Potter, M. D., Buffalo, N. Y.

Complications in Pelvic Surgery, and How to Deal with Them, Joseph Price, M. D., Philadelphia, Pa.

Cholecystotomy—Report of Case—52 Gallstones and 10 ounces of Pus Removed—Success, W. B. Rogers, M. D., Memphis, Tenn.

Some of the Complications of Psoas Abscess, J. McFadden Gaston, M. D., Atlanta, Ga.

Laparotomies Performed in the Past Year, Thomas Opie, M. D., Baltimore, Md.

Imperforation of the Rectum, Geo. Ben. Johnston, M. D., Richmond, Va.

A Case of Induced Abortion for the Relief of the Nausea and Vomiting of Pregnancy, with Remarks, Christopher Tompkins, M. D., Richmond, Va.

The Principle of Drainage as Applied to Surgery of the Deep Urethra, F. W. McRae, M. D., Atlanta, Ga.

The Neuroses of the Genito-Urinary System in the Male, Frank Lydston, M. D., Chicago, Ill.

Nephrectomy, with Report of Cases, Edwin Ricketts, M. D., Cincinnati, O.

Venomous Serpents of the United States, and the Treatment of Wounds Inflicted by Them, Paul B. Barringer, M. D., University of Virginia.

A Report of Some Additional Cases of External Perineal Urethrotomy Without a Guide, J. Edwin Michael, M. D., Baltimore, Md.

Growth of Fibroid Tumors of the Uterus after the Menopause, Jos. Taber Johnson, M. D., Washington, D. C.

The Part the Shoulders Play in the Production of Laceration of the Perineum, with Suggestions for its Prevention, W. D. Haggard, M. D., Nashville, Tenn.

The Pedicle in Hysterectomy. How Formed. Its Subsequent Behavior. Its Final Condition, I. S. Stone, M. D., Washington, D. C.

A Case of Pelvic Abscess, John Brownrigg, M. D.,  
Columbus, Miss.

A Case of Cyst of the Mesentery, with Remarks, J. A.  
Goggans, M. D., Alexander City, Ala.

The Female Urethra, K. P. Moore, M. D., Macon, Ga.

Medico-Legal Aspect of Intestinal Surgery, J. D. S.  
Davis, M. D., Birmingham, Ala.

Albuminuria; Its Relation to Surgical Operations, J. W.  
Long, M. D., Randleman, N. C.

Senile Gangrene, Frank Prince, M. D., Bessemer, Ala.

Hemorrhage *versus* Shock, W. L. Robinson, Danville,  
Va.

Treatment of Gallstones, with Report of Cases, W. E. B.  
Davis, M. D., Birmingham, Ala.

(Title of paper not determined), Hunter McGuire, M.  
D., Richmond, Va.

(Title of paper not determined), Duncan Eve, M. D.,  
Nashville, Tenn.

(Title of paper not determined), A. V. L. Brokaw, M.  
D., St. Louis, Mo.

(Title of paper not determined), Chas. A. L. Reed, M.  
D., Cincinnati, Ohio.

(Title of paper not determined), W. F. Westmoreland,  
M. D., Atlanta, Ga.

Members of the medical profession cordially invited to  
attend.

LOUIS McMURTY, M. D.,  
*President.*

W. E. B. DAVIS, M. D.,  
*Secretary.*

#### AMERICAN DERMATOLOGICAL ASSOCIATION.

The fifteenth annual meeting was held at Washington,  
September 22 to 25, 1891, in conjunction with the Congress of  
American Physicians and Surgeons.

The meeting was called to order by Dr. F. B. Greenough,  
of Boston, who made the opening address.

The report of the committee on nomenclature was made  
and after discussion was accepted.

The first paper read was by Dr. H. G. Klotz, of New  
York, entitled "Dermatitis Hæmostatica." It was discussed  
by Drs. Piffard and Bronson.

Dr. L. A. Duhring, of Philadelphia, followed with a paper,  
"Report of a Case of Universal Erythema Multiforme." It  
was accompanied by a colored portrait of the case and speci-

mens of large plates of exfoliated epidermis shed by the patient during the latter part of the course of the disease. It was discussed by Drs. Hyde, Duhring, Sherwell, Shepherd, Fox, Allen and Bronson. Dr. Shepherd asked if any drug had been administered for the rheumatism that was a marked feature in the case, to which Dr. Duhring replied, "No! The treatment had been entirely negative." Dr. Fox had seen a case somewhat resembling that of Dr. Duhring in which there was a question if the eruption had been caused by some drug that had been taken for a co-existing gonorrhœa. He thought that it was a purely accidental occurrence. We often see cases of dermatitis exfoliativa following other diseases, such as psoriasis.

Dr. Shepherd, of Montreal, then read a paper upon "An unusual Case of Sarcoma involving the Skin of the Arm, requiring Amputation."

This was followed by a paper by Dr. S. Sherwell upon "Multiple Sarcomata. History of a Case Showing Modification and Amelioration of Symptoms with Large Doses of Arsenic." In the discussion Dr. Zeisler mentioned brilliant results in a case of lupous sarcoma for the administration of arsenic. In a case of pigmentary sarcoma he had given the drug without effect. Dr. J. C. White, of Bston, had seen good effects from the use of the drug in one case of sarcoma. Dr. Robinson, of New York, had not much success with arsenic. He believed that many cases of multiple sarcoma were in reality microbian in origin and not true tumors.

The next paper read was by Dr. R. B. Morrison, of Baltimore, on "The Hypodermic Use of Hydrargyrum Formamidatum in Syphilis," which he recommended as a treatment of great usefulness, specially as a means to fall back upon in some cases in which older forms of treatment did not succeed, or in which such a plan as that of inunction was not practicable. He always used Merck's preparation and found that it did not cause much pain nor prove objectionable. He had never used any of the insoluble salts. In the discussion Dr. Corlett said that he had found hypodermic injections of mercury of great use in some cases, such as in those cases in which the stomach has given out. Dr. Klotz had employed hypodermic injections in syphilis. While it was doubtless of value in some cases, for most cases older methods of treatment are quite as good. Dr. Greenough said that while greatly interested in the subject of hypodermic medication in syphilis, he had found it impossible to get his patient to submit to it. He thought it was useful only in exceptional cases in which other plans could not be used. Its ultimate result was no better than that of other plans.



Dr. J. Grindon, of St. Louis, read a paper upon "Lichen Scrofulosorum," which gave rise to a long discussion. Drs. Robinson, Piffard, Sherwell, Shepherd, Corlett, Bronson and Greenough, all had seen cases of this rare disease.

Multiple Sarcomata of Skin. History of a case showing modification and amelioration of symptoms with large doses of arsenic. By Dr. S. Sherwell, Brooklyn.

The author after pointing out numerically several interesting points, chief among which were, largeness of therapeutic dosage, tolerance of them by patient, complete and rapid subsidence of tumors under such dosage, rapid recurrence under suspension of same, originality of treatment instituted, etc., goes on to give a history of the patient with sarcomata, supplemented with a further history by Dr. John B. Wheeler, of Burlington, Vt.

Dr. Sherwell removed in all from this patient thirty growths, some of which were quite large, one three and one-fourth inches in diameter; Dr. Wheeler, about a year later, in a series of operations, removed the immense number of 170, large and small. In the interval between his leaving Dr. Sherwell's care and coming under that of Dr. Wheeler, he had interrupted or almost suspended treatment spoken of above, which had at the time of his leaving Dr. Sherwell caused the complete, or almost complete, disappearance of all growth. They recurred too rapidly for Dr. Wheeler to operate, when Dr. Wheeler adopted some internal treatment, as that which Dr. Sherwell had instituted, with the most decided and gratifying results, namely, the same rapid disappearance of the growths. The case ended by his leaving Dr. Wheeler's care in good condition and doing exceedingly well, irregularity or total interruption of treatment, and as before recurrences of growths, followed in a few months by death.

#### SECOND DAY—THURSDAY, SEPTEMBER 23, 1891.

The committee on statistics made its report through its chairman, Dr. J. H. Hyde, of Chicago.

This was followed by a discussion on "Tuberculosis of the Skin," which was opened by Dr. J. C. White, of Boston, who presented "Its Clinical Aspects and Relations;" by Dr. J. T. Bowen, of Boston, who presented "Its Pathology;" and by Dr. G. H. Fox, of New York, who presented "Its Treatment." In the discussion, Dr. H. G. Piffard drew attention to the fact that French and other competent observers had surmised the connection between what was then called pulmonary consumption and lupus and the so-called scrofulodermata. He had done so in 1878. Recent invention of the Abbe condenser

and Zeiss lenses had enabled us to discover the tubercle bacillus, and to establish the relationship on pathological grounds. He himself believes that lupus erythematosus is fully entitled to the name "lupus," as he thinks that it, too, is of bacillary origin. Nor is he alone in his opinion. Cold abscess of the skin is probably due to the same cause, as is also rodent ulcer. He would agree with Dr. White in believing that we should have some collective term for all the various tubercular diseases. In treatment he would advocate cutting out the whole diseased patch, unless it was very extensive. Next to the knife he would place the actual cautery, after removal as much as possible of the growth with the curette. Arsenic and chloride of zinc are also to be depended on.

Dr. C. W. Allen commended multiple scarification; and combined pyrogallol and mercurial plasters; he thought that there might yet be a future for Koch's tuberculin.

Dr. J. Zeisler was in thorough accord with Dr. White. By his experience at the Hospital St. Louis he had become converted to the use of the galvano-cautery. He would also testify to the efficacy of the solid nitrate of silver stick which, bored into the skin, would act both as a knife and caustic. He was not enthusiastic as to tuberculin.

Dr. E. B. Bronson believed that it was best to retain for some time our present terminology for the different tubercular diseases. In regard to tuberculin, he had seen improvement in some cases treated with it, but on the whole his experience had made him regard the remedy unfavorably. He had had good success with the dental-burr, as first advocated by Dr. G. H. Fox. The nitrate of silver stick was also good.

Dr. J. N. Hyde was glad that Dr. White had come to accept local contagion as the cause of lupus, a view that he himself was among the first to advocate. He thought that in this country there were but few cases of lupus with a history of pulmonary tuberculosis in the family, or with tubercular diseases elsewhere. He did not believe in the treatment of scarification. Both the curette and nitrate of silver were serviceable in proper cases. In regard to tuberculin, he thought it possible that in time we might find something of value in it, but it was not so now.

Dr. L. A. Duhring would retain the old names for some time to come. He had not found lupus associated with general tuberculosis in private practice. He would recommend pyrogallol most highly, using it in the form of a plaster with resin and soap plaster, three of the resin plaster and one of the soap plaster. This is to be worn continuously. Local use of bichloride of mercury he had not found beneficial. Tuber-

culin he had found helpful, though he did not report any case of cure.

Dr. P. A. Morrow would agree with Dr. White that as lupus and some other diseases had a common etiological factor, we should place them together under a common heading. He advocated the use of multiple scarifications followed by mercurial plaster. For destruction of the small lupus nodules he recommended punctate cauterization with a wite hot instrument. Chloride of zinc was superior to pyrogallol as a caustic. Excision will probably increase in favor as the means of treating lupus.

Dr. A. R. Robinson would not include lupus under a common heading with tuberculosis on account of its different clinical aspect.

Dr. H. G. Klotz was not yet satisfied with our present knowledge of the infection of the skin with the bacillus tuberculosis.

Dr. L. D. Bulkley is not satisfied with any of the plans for the external treatment of lupus. Internally he has great faith in phosphorus as a curative agent, the nodules softening up and disappearing under its continuous use. He would corroborate Dr. Fox's advocacy of fuchsin. As to pyrogallol, that too was admirable. He applies it in powder form, pure, after scraping. Salicylic acid combined with pyrogallol is also useful.

Dr. S. Sherwell was doubtful of the relationship of tuberculosis to lupus. (Adjourned.)

#### THIRD DAY.

Dr. Duhring read a paper upon "Notes of a visit to the Leper Hospital of San Remo, Italy." In reply to a question by Dr. White, after the paper was read, he replied that no attempt at segregation was made in San Remo. There were but few cases in the Hospital and they were in an ordinary Ward of a general Hospital. They were not permitted to leave the confines of the Hospital.

Dr. P. A. Morrow, of New York, then followed with a paper on "Skin Grafting," and showed a case in which the operation had been done by the method described by him, and with admirable results.

In the discussion of the case Dr. Duhring spoke in high praise of the operation of skin grafting as practised by Dr. Jas. E. Garrettson. Dr. Clark asked if Dr. Morrow thought that the inclusion in the graft of the deeper structures of the skin, as recommended by him, would give any better results than more superficial ones. To this Dr. Morrow replied that



he thought they would be more certain to take, and he had had not a single failure. He had made more than fifty grafts of hairy skin upon a cicatrically bald scalp and all of them had taken, and from many of them the hair was growing nicely. Dr. Sherwell had had good results, also, by deep grafts.

Dr. P. A. Morrow, of New York, then read a paper on "The Treatment of Alopecia Areata," and was followed by Dr. L. D. Bulkley, of New York, with a paper on "A Therapeutic Note on Alopecia Areata." The two papers were discussed together. Dr. J. Zeisler believed alopecia areata was due to a parasite, though perhaps there were some cases due to a neurosis. The latter were the very obstinate ones. He was in favor of treating all cases by epilation about the patches. With pilocarpine he had had no success. He regarded the use of a concentrated solution of common salt as a good remedy for stimulating hair growth.

Dr. W. T. Corlett spoke in favor of acetic acid as a remedy in alopecia areata. Cases, however, recovered spontaneously.

Dr. G. H. Fox was always pleased to hear any one speak with confidence of any treatment of alopecia areata, as Dr. Bulkley had done of carbolic acid. He was rather skeptical of any remedy. A strong solution of ammonia had proved as effective as any in his hands. He thought that general treatment of the patient was quite as important as any local application. Dr. J. E. Graham had never seen any cases that would lead him to believe that alopecia areata was contagious. He did not think that because antiparasitic remedies were useful that this was a proof of the parasitic nature of the disease. Dr. P. A. Morrow thought that there had been a sufficient number of cases of contagion reported to satisfy any reasonable doubt of the contagiousness of the disease. He quoted Eichhoff's report, in which a number of cases were traced to one barber. He had had one case of probable contagion.

Dr. L. A. Duhring said that in spite of a great deal of study of alopecia areata, he had never been able to find any parasite in the disease, nor to be convinced that the disease was contagious. He believed that there was a disease simulating alopecia areata, and often reported as such, that sometimes occurred epidemically, but was not alopecia areata. He regarded arsenic taken internally as very valuable in the treatment of the disease. He could see no reason for depilating the healthy hair about the patches.

Dr. J. C. White said that we were still wanting positive evidence of both the parasitic and the neurotic element in the etiology of the disease. Clinical evidence points both ways.

He had seen cases of apparent contagion. He had seen thirty cases of a disease simulating alopecia areata, and that were not cases of ringworm, occurring in an asylum, which probably were instances of the so-called contagious alopecia areata. He did not think that they were true alopecia areata. His favorite remedy was half a drachm of croton oil to eight ounces of turpentine, used daily. Of course it failed in some cases, as do all remedies. If it failed he used many other remedies that had been commended, but they did not do any better. He did not believe that there was any specific remedy.

Dr. H. W. Stelwagon had never been able to trace a case to a contagious origin. Local stimulation is more to be relied on in treatment. He was fond of equal parts of turpentine, cantharides and tincture of capsicum, with arsenic internally.

Dr. J. N. Hyde believed that the time would come when alopecia areata would be regarded as simply a symptom. Some cases were doubtless parasitic and some neurotic in origin. In bad cases he used creosote locally. After say the 45th to the 48th year of life the chances of recovery were greatly decreased.

Dr. H. G. Keotz had had one case in which hereditary syphilis was probably the underlying cause, the boy getting better when under specific treatment.

Dr. C. W. Allen believed that the disease was parasitic and thought that he had in his own practice observed a case of contagion. He thought that internal treatment was valuable. Naphthol and pyrogallal had both proved useful in his hands.

Dr. S. Sherwell believed the disease to be of neurotic origin alone. Stimulation was most to be depended on.

Dr. J. Grindon had never met with a case that suggested either a parasitic or contagious origin of the disease. He believed in its trophoneurotic origin.

Dr. F. B. Greenough used in practice a half drachm of carbolic acid in an ounce of water.

Dr. L. D. Bulkley, in reply to a question of Dr. Morrow, said that he used the 95 per cent. solution of carbolic acid only to a small portion of the scalp at a time. It should be brushed over lightly at first so as to benumb sensibility and then rubbed in more thoroughly. He had not used it elsewhere than on the scalp. The skin is red for a few weeks; this disappears and the hair grows. He also administers strychnia and phosphoric acid, and keeps up the nutrition of the patient.

Dr. R. W. Taylor, of New York, read an account of a case, "*Angioma Pigmentosum et Atrophicum*," by Dr. A. W. Brayton, of Indianapolis. It was accompanied by an excellent portrait.

Dr. J. C. White stated that his investigations showed that the disease was not limited to Russian Jews, but was met with also in persons of English and French descent.

Dr. Bronson then read his paper upon "The Etiology of Pruritus."

#### THIRD DAY—AFTERNOON SESSION.

It began with a short discussion of Dr. Bronson's paper on pruritus, in which Drs. Zeisler and Morrow took part, the discussion being closed by Dr. Brown Bronson. Dr. W. T. Corlett, of Cleveland, then read a paper upon diseases of the skin, associated with derangement of the nervous system. It was discussed by Drs. Bronson, White, Fox, Duhring, Zeisler, Allen and Sherwell, who took various views of the cases reported, all agreeing that it was very difficult to diagnose what the causes were without having seen them.

Dr. L. A. Duhring read his paper entitled "Experiences in the treatment of chronic ringworm in an institution for boys." He recited the many remedies he had used. In the discussion Dr. G. H. Fox said that Dr. Duhring's experience was both interesting and valuable. He had had considerable experience in the New York Skin and Cancer Hospital. He had found chrysarobin useful, as had Dr. Duhring. He began the treatment by clipping the hair short, and shaving, either only over the patches or over the whole scalp, and applying chrysarobin in traumatization. He was tired of greasy applications. Hydronaphthol plaster, as recommended by an European physician, had proved more satisfactory than chrysarobin. He advocated epilation where practicable.

Dr. J. Zeisler advocated pyrogallol as a parasiticide. Dr. Duhring, in reply to a question, said that some of the cases recovered in six weeks, and some not for a year. Dr. White thought that white chrysarobin was a good remedy. It was not a safe one to use outside of an asylum or hospital. He recommended a combination of sulphur, carbolic acid and naphthol in ointment form. Dr. Stelwagon recommended an ointment composed of tar, sulphur and citrine ointment. Dr. Sherwell advised keeping the scalp saturated with a mild oil and covered by a skull cap. Dr. B. Wigglesworth believed that it is necessary for us to have regard to the nutrition of our patients. Dr. C. W. Allen bore testimony to the value of chrysarobin. Dr. L. A. Duhring in concluding said that the cases were all well when he left off treatment, and that they remained well for at least one year. Epilation he found did not repay the vast amount of labor it cost. He regarded ointments as most useful remedies.

Dr. J. Zeisler, of Chicago, then read his paper on "Epi-



lation; its range of usefulness as a dermato-therapeutic measure." In the discussion, Dr. G. H. Fox said that he was glad to hear any one advocate epilation in sycosis, as he had found it a most useful remedy. A sulphur paste after epilation is valuable. He had not found epilation so promptly curative as had Dr. Zeisler, while he laid more stress on diathetic management than did the latter. He was sure that epilation was useful in some cases of chronic ringworm of the scalp. Dr. H. G. Klotz spoke also in favor of epilation in sycosis, though he had cured many cases without it, notably with mild naphthol ointments. He thought epilation to be valuable in syphilitic lesions about the hairs, as well as in all the pustular affections implicating the hair. Dr. L. A. Duhring had not been able to practise epilations on his patients on account of the pain it caused, specially on the upper lip. He could not see much use in epilating in alopecia areata when the hairs were firm about the patch. Dr. P. A. Morrow said that he did not think that it was necessary to pull out all the hairs about the bald patches, but it was a good thing to make traction on all of them and to remove all that were loose. Epilation was a requisite in all rebellious cases of trichophytosis. If the hair is removed by a quick, sudden movement, the operation is nearly painless. Dr. H. W. Stelwagon believed that many cases of sycosis could be cured without epilation. He would speak in special praise of Fleming's solution in trichophytosis, diluting it at first one part to five or six of water, and gradually increasing the strength to just short of marked irritation. Dr. S. Sherwell spoke of the connection between catarrhal conditions of the nose and sycosis of the upper lip. Dr. J. H. Hyde said that the last time he was in London and Paris he had observed that epilation was quite generally practised about the patches of alopecia areata. In closing, Dr. Zeisler said that when epilation was properly performed it was almost painless. As he regards alopecia as a parasitic disease spreading at the periphery he epilated about the patches to stop their spreading.

#### FOURTH DAY—MORNING SESSION, SEPTEMBER 25, 1891.

The first paper was by Dr. J. E. Graham upon "*Molluscum Contagiosum*." Dr. Bowen said that there was little question but that the disease was contagious. It is still unproven whether certain bodies found in mollusca are or are not coccidial. Dr. Allen had no doubt about the contagiousness of the disease and related cases of the disease spreading in an asylum from one case. Excision is never necessary. They can readily be squeezed out, and then lightly touched

with a caustic. He believed in their parasitic origin. Dr. E. Wigglesworth likewise cited a case of contagion. Dr. J. C. White while believing that molluscum was contagious, was not prepared to accept the psorosperm as its cause. Dr. J. N. Hyde pointed out that in the statistics for the year just closed seventeen cases of molluscum contagiosum were reported, viz: Nine from Boston, five from New York, two from Chicago, and one from St. Louis. Dr. F. B. Greenough believed them to be contagious. In treatment he simply bores them out with nitrate of silver stick. Dr. S. Sherwell concurred in the belief of their contagion. Dr. J. E. Graham thought from evidence so far brought forward, that the so-called psorosperms were simply degenerated epithelial cells.

Dr. J. N. Hyde, of Chicago, then read his paper, "Note relative to Pemphigus Vegetatus." In the discussion Dr. L. A. Duhring said that he had had the opportunity of seeing the case described and would corroborate what Dr. Hyde had said of it. It certainly was more of the nature of pemphigus than anything else. Dr. Bowen had seen a case of Neumann's in Vienna, and this one brought that one back very vividly to his mind. He regarded the term "pemphigus" as a most indefinite one, and thought that it gave very little idea of the pathology of the case under discussion. Dr. S. Sherwell had seen a case with analogous symptoms in a woman which was cured by ovariectomy. Dr. J. E. Graham related the history of a similar case of his own. It became much better under arsenic, but suffered a relapse.

Dr. J. N. Hyde, in closing, said that in his case there was no disease of the ovaries. He regarded the prognosis in his case as not good.

Dr. H. W. Stelwagon then read his paper on "A Study of Mycosis Fungoides." It was discussed by Drs. Hyde, White, Hartzell, Bowen, Duhring and Fox. Dr. Hartzell emphasized the infectious nature of the tumors, and thought that we must look to inoculation experiments for the proof. Dr. Bowen spoke of the disagreement among pathologists in regard to the nature of the tumors. Dr. Duhring said that the disease was a general one of the skin, and did not seem to affect other organs to any extent. He believed it to be an infectious disease. It may be regarded as on the border line between an inflammatory new growth and a tumor. Dr. Fox related a case of apparent infection of the disease in the New York Skin and Cancer Hospital. He also spoke of the early diagnosis of the disease, and reported a case that at first looked like an eczema marginatum, but afterward developed the characteristic tumors. Dr. Stelwagon, in closing, said that he

found, in looking up the literature of the disease, some fifty or a hundred reported cases. It was exceptional for the disease to begin as tumors.

Dr. M. B. Hartzell, of Philadelphia, then read his paper on "Lymphangioma Circumscriptum, with report of a peculiar case." It was discussed by Drs. Stelwagon and Bowen.

Dr. H. G. Klotz, of New York, followed with a paper: "Remarks on Carbuncle, with report of a peculiar case." It was discussed by Dr. Bowen, who spoke of the remarkable paper by Dr. Warren, of Boston, describing the pathological anatomy of the disease.

Dr. C. W. Allen then made some remarks on "Erythema Nuchæ." Dr. Zeisler thought it probable that erythema nuchæ was often due to pressure and rubbing. Drs. Fox, Duhring, Grindon and White also took part in the discussion.

Dr. J. Grindon read a paper on "A Case of Lichen Ruber." Dr. Zeisler would be inclined to view the case as one of lichen planus. In this disease plantar and palmar thickenings are apt to form. Arsenic often cures these patients. Dr. S. Sherwell agreed with Dr. Zeisler in his diagnosis, though the case presented many exceptional features; one especially being the involvement of the nails. Dr. White believed the case to be one of lichen planus and spoke of the uncertainty surrounding the whole question of the lichen group. Dr. Hyde said that he always found the polygonal outline of the popules to be well marked, something that does not seem to be familiar to the Germans and French. Dr. Duhring agreed with the previous speakers in this diagnosis. The polygonal shape and umbilication are often wanting. Adjourned.

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ALLEGHENY COUNTY MEDICAL SOCIETY, SEPTEMBER 15, 1891.

ETIOLOGY AND PATHOLOGY OF THE PNEUMONIAS.

BY J. CHRIS LANGE, M. D., Pittsburgh, Pa.

*Mr. President and Gentlemen:* There are, in medical literature, more than thirty terms used to qualify the inflammation called pneumonitis, and some confusion as to the seat, products and nature of this process is a result. The endeavor to classify these inflammations can be successful only from the standpoint of the lesion, *i. e.*, their macroscopical and microscopical appearances; and while it is true that, clinically, and pathologically also, there is no absolute line of demarcation between them, it is equally true that every inflammation of the lung presents lesions sufficiently characteristic to justify its holding a place in one of three classes. Nevertheless, these



classes are not anatomically distinct, and it is important to recognize their relation to each other and the very close relationship all hold to phthisis; for phthisis consists essentially of pneumonias—is an inflammatory process always and involves the substance of the lung always.

These three classes present the following characteristics:

#### CROUPOUS PNEUMONIA.

Coagulable fibrinous exudation, seat in the air cells, extension to the ultimate bronchioles, involves one or more lobes, usually unilateral, acute, primary.

#### CATARRHAL PNEUMONIA.

Non-coagulable exudation, seat in ultimate bronchioles, extension to air cells, involves the cones supplied by one or more bronchial tubes in each lung, bilateral, acute or chronic, secondary.

#### INTERSTITIAL PNEUMONIA.

Hypertrophy and contraction of connective tissues, seat in connective tissue, involves part of one or more lobes in one or both lungs, unilateral or bilateral, acute or chronic, primary or secondary.

An endeavor to bring into these three classes all forms of this inflammation, clinically so very different, results in the following table:

Croupous Pneumonia.—Lobar, genuine, true, fibrinous, pleuro-pneumonia, central, crossed, typhoid, bilious, traumatic, narcotic, cerebral, epidemic, endemic, drunkards', senile, delayed.

Catarrhal Pneumonia.—Lobular, broncho-pneumonia, tubercular, cheesy, inhalation, deglutition, hypostatic, typhoid, drunkards', senile, children's.

Interstitial Pneumonia.—Fibrous, contracting, sclerotic, atrophic, syphilitic, pneumonia alba.

Senile and drunkards' pneumonia may be croupous or catarrhal. The same is true of typhoid pneumonia, which is so-called when, not typhoid fever, but the "typhoid state," is present. The pneumonia of children under 8 is almost always catarrhal; over this age the liability to the croupous form increases with each year. Delayed resolution pneumonia is applied to a form of croupous inflammation in which the exudate is not liquefied and absorption is delayed. Cerebral pneumonia is croupous, and follows concussion of the brain, particularly in children. Narcotic pneumonia is croupous, and follows recovery from opium poisoning. Bilious pneumonia is so quali-

fied when the patient presents the slight jaundice resulting from congestion of the liver by contiguity to the inflamed lower lobe of the lung. Central pneumonia lacks the stitch until the inflammation reaches the periphery and adds the fibrinous pleurisy. A crossed pneumonia involves the upper lobe of one and the lower lobe of the other side. Traumatic pneumonia is croupous, and follows concussion of, or blows upon, the thorax.

The etiology of croupous pneumonia is not determined. The proposition that it is an acute infectious disease, the micrococcus of Friedlander being its pathogenetic agent, rests upon laboratory experiments, clinical facts, and observations of considerable weight, and is deserving of all consideration. Croupous pneumonia, if infectious, all other alleged causes fall to the rank of predisposition. Weather vicissitudes, heavy lifting and blows upon the chest, which are almost always considered to constitute the cause of the inflammation, must be considered when followed by the chill and stitch as coincident only, the inflammation having begun previous to such exposure. Every physician has knowledge of cases of which this is an improbability. But it is always a possibility. Endemics of pneumonia, and some have been malignant, are most readily explained by infection. The same is true of epidemics. Allowing that the identity of the element the atmosphere, which has been believed to be causative of pneumonia, is unknown to us; that it is neither cold, humidity, altitude, electrical influence, nor fall or rise of temperature, it becomes impossible to explain epidemics, endemics and perhaps a' croupous pneumonias, except by infection. The fact that individual predisposition is established, that age has an influence, and that the inflammation occurs presenting the phenomena common to infectious diseases—for instance, the "typhoid state"—is additional evidence in favor of infection.

On the other hand, every physician is familiar with cases in which the seemingly obvious causes of the inflammation were exposure, concussions, etc., and he has frequently verified the potency of the predisposing causes—alcoholism, poverty, gout, rheumatism, Bright's disease, etc. Again there is the undeniable frequency of croupous pneumonia in areas whose climate is marked by rapid and frequent changes of humidity and temperature; and its undoubted frequency where and when other inflammations, such as coryza, tonsilitis and bronchitis, prevail. In addition, Friedlander has not always found the capsule-coccus in croupous pneumonia, and identical cocci have been demonstrated in other conditions. Talamon has produced pneumonia by the injection of this coccus, but also by injection of other cocci; and Friedlander himself now

admits that the distinguishing capsule of the pneumo-coccus may be simply accidental—an imperfection of staining or decolorization. These facts leave the etiology of croupous pneumonia undetermined.

The point of departure from the normal in croupous pneumonia, the primary histological process consists of injury and partial destruction of the pavement epithelium of the air cell and ultimate bronchiole produced by the cause—be this specific or not—of the disease. The anatomical process consists of the filling of air cells and bronchioles with a hemorrhagic coagulable exudate, and since the time of Lænnec is described in three stages, viz.: engorgement, active congestion of the pulmonary and bronchial capillaries; red hepatization, the time of the coagulated exudate and gray hepatization, the time of its liquefaction. During the latter stages the lobe, excepting its bronchial tubes, is airless, friable, enlarged and increased in weight by from two to three pounds. These three stages having been accomplished, the liquefied exudation is absorbed and a rapid and complete restoration follows in a majority of cases. In a minority of cases this does not happen, and we recognize a fourth "stage of purulent infiltration." And by the occurrence of this stage we appreciate the close relationship of croupous pneumonia to phthisis. This fourth stage is chronic pneumonia, or abscess, or gangrene.

By a termination in chronic pneumonia is understood an hypertrophy of the pulmonary connective tissue, due to its irritation by the inflammation or exudate, or both; and although the exudate is entirely or almost entirely absorbed, its presence during the inflammation, or the inflammation itself, has been an irritant sufficiently active to begin this connective tissue-hyperplasia. And it continues. In other words, such a croupous pneumonia is transformed to a pneumonia of the third class, an interstitial pneumonia, and under that head its further progress will be noted.

If the termination of the fourth stage be in gangrene, which is usually found in isolated small portions of the lobe, then there has happened an additional new infection by a putrid substance. If recovery ever happens in such a case, it can be only by an hyperplasia of connective tissue—*i. e.*, by an interstitial pneumonia.

If the fourth stage terminate in abscess, then, again, interstitial pneumonia is the only possible process of restoration. Whether the occurrence of abscess depends upon a new infection, or whether this may exceptionally happen from the presence of the croupous exudate is not definitely determined.

Catarrhal pneumonia is not, like the croupous form, a dis-



tinct disease. With the exception to be mentioned, it is always preceded by bronchitis. This bronchitis may be primary; but primary mild bronchitis is rarely followed by catarrhal pneumonia. This is a frequent result, however, of the bronchitis of whooping cough, measles and influenza, which is intense, and extending, becomes pneumonia. Any violent or prolonged bronchitis, particularly in the young, the old and the feeble, deserve high rank in the etiology of catarrhal pneumonia.

Another cause is the bronchitis common during the existence of grave and protracted diseases. Here all conditions are peculiarly favorable for the occurrence of the extension of bronchial inflammation. Everywhere in the air passages as well as in the mouth and pharynx, particles of food, mucus and saliva collect and remain. This is favored further by the constant dorsal decubitus. Fungi and bacteria, decomposition agents, find everywhere conditions favorable to development and increase. From upper situations they are drawn downward, invade the fine bronchioles, producing catarrhal pneumonia. Many patients have difficulty in swallowing; frequently they choke; frequently they inhale particles of food, secretions of mucus, and do not, like persons who are well, cough up. Such particles remain, decompose, and originate bronchitis and its extension, catarrhal pneumonia. This is the explanation why this inflammation occurs so frequently in diseases entirely dissimilar. It happens especially in patients with stupor, in severe typhoid, in meningitis, and in bulbar diseases where cough and deglutition are impaired. So originating, these inflammations have received the names inhalation and deglutition pneumonias.

A constant dorsal decubitus in conjunction with a weak heart is a third cause of catarrhal pneumonia. This is probably the only manner in which this inflammation can be induced without a preceding bronchitis. The first step is a passive congestion limited to the posterior borders of both lower lobes; very soon there is added to this an œdema equally limited; congestion and œdema is splenization, and this induces the inflammation characteristic of catarrhal pneumonia, this being called hypostatic. This different origin is followed by an anatomical difference between this hypostatic and all other catarrhal pneumonias. It is that all other forms must necessarily be located about the ramifications of the bronchial tubes from which they originated—*i. e.*, must always exist in cones—while this hypostatic pneumonia is not so limited, but involves adjacent alveoli, independent of their bronchial supply, from the lower border of both lungs, a little or a great way up. Although each of these pathogenetic conditions is entirely com-

petent to produce catarrhal pneumonia, two or all frequently act together.

The termination of catarrhal pneumonia, when this is not restoration, is abscess, gangrene or the so-called "transition to tuberculosis." Abscesses, when small and not numerous, may be emptied through bronchi, interstitial pneumonia then obliterating the cavities or become encysted and cretified, forming lung stones. Both results are innocuous. Gangrene requires a special additional infection. There remains the "transition to tuberculosis."

What is here said applies to abscess following croupous as well as catarrhal pneumonia. Excepting that the abscesses in the former may be confined to one lobe, while in the latter they may be upon both sides, they proceed substantially upon the same course and terminate in the same manner. Both are non-tubercular phthisis. Both present consolidation; the first consists of pus and the lung tissue involved in the abscess, the last of caseation of the catarrhal exudate and the lung tissue it embraces. Both soften, break down the involved lung tissue, and are extruded through the bronchi. Both leave cavities which enlarge by peripheral ulceration, and both conduct their victims to death by exhaustion from hectic and hemorrhage.

There should be now no question of a "transition to tuberculosis." With our present knowledge we can understand perfectly well how cavity ulceration conducts patients to death without the assistance of tubercle: and the time is past when every cheesy nodule must be tuberculous. Non-tubercular phthisis following croupous and catarrhal pneumonia deserves and now has recognition as a destroyer of mankind. Although there can be no "transition to," there frequently is infection by tubercle. Everything, all the conditions in abscess, whether this follow croupous or catarrhal pneumonia, is most favorable to infection, and, therefore, the termination in a majority of such cases is in tubercular phthisis. Further, patients with undiscoverable tubercular deposits are, like all other persons, subjects to croupous and catarrhal pneumonia; in such a case, the pneumonia, if it terminates in phthisis, this latter will, of course, be tubercular. Therefore, tubercular phthisis, when it follows a pneumonia of either variety, depends upon a pre-existing, perhaps undiscoverable, tuberculosis, or the patient is infected with tubercle during the time of existence of the pneumonia. In either case there can be no question of transition.

Interstitial pneumonia, finally, is a low and chronic inflammation situate in the pulmonary connective tissue, which tissue, according to its situation, is called intercellular, inter-

lobular, peri-bronchial, peri-vascular and sub-pleural. Inflammation of this tissue is provoked by any irritant, and its intensity and extent depend upon the activity and persistency of the irritant. It is frequently a beneficent, a compensatory process. This is so when it obliterates abscesses, encapsules cheesy nodules, insulates hemorrhagic infarctions, or closes phthisical cavities. Then it holds the place of a cicatrix of the skin, and is compensatory and beneficent. But it is frequently also a most malignant growth and destructive of air cells, blood vessels, bronchial tubes and all lung tissue. For its inflammation produces a hyperplasia, a hypertrophy, and, like young connective tissue in every situation, contracture; so that frequently the lung affected by its proliferation and contracture—*i. e.*, by pressure—becomes a hard, fibrous, airless, white mass, with distorting bands running through it in every direction. And this property and action constitutes its relationship to phthisis. By its distortion and occlusion of bronchial tubes, these latter dilate between their point of injury and their origin, forming bronchiectases, which dilations become secretion depots. Their contents are infected and soon putrefy. Then peripheral ulceration of the dilated tube walls begins; the bronchial wall is perforated, and a cavity in the substance of the lung results. This is fibroid phthisis.

The irritants which produce this malignant train of processes are especially three, viz: iron, coal and stone; and for this reason this disease has been called the iron, or stone or coal lung, and knife-grinders' consumption, and mechanical phthisis. Particles of iron, coal or stone are found in the pulmonary connective tissue; for, though penetration through the bronchial wall is impossible where this is armed with ciliated epithelium, this defence ceases at the ultimate bronchiole and air cell, and it is here these irritants penetrate and are followed by the disastrous results indicated.

Irritants less sharp and less persistent induce a lesser degree of inflammation. For instance, an abscess resulting from croupous or catarrhal pneumonia irritates its surrounding connective tissue only to the extent sufficient to empty and obliterate the abscess and to form a cicatrix of its walls. A cheesy nodule irritates it to the degree necessary to produce an encysting capsule. A phthisical cavity also is contracted, emptied and cicatrized by this tissue in consequence of the irritation itself produces. Cicatrization or encapsulation having happened in this manner, no irritant remains, and hyperplasia ceases. This does not happen invariably, however; sometimes this process continues, and, when so, destruction of



lung tissue by pressure and distortion, and by cavities of bronchiectases, follow.

A very decided interstitial pneumonia, usually not advancing to phthisis, however, frequently follows chronic pleurisy and empyema; here the large area of sub-pleural connective tissue has been irritated by the adjacent inflammation and supuration, and some hypertrophy and contraction follow. This is, probably, at least a factor in the prevention of complete expansion of the lung after an empyema has been cured. Also a limited interstitial pneumonia is common in the peri-bronchial connective tissue around such tubes as have been long involved in a chronic bronchitis. In short, interstitial pneumonia signifies a process often reparative and compensatory, and fibroid phthisis the same process pregnant with a slow, but sure, destruction of lung tissue.

#### DISCUSSION.

Dr. Kearns—I wish to congratulate the doctor on his paper, which was both entertaining and instructive. It should stimulate us to greater care and perseverance in diagnosticating these different forms of pneumonia. One of the classifications spoken of by the doctor has been but recently established, and that is traumatic pneumonia. It has been contended by men of very great experience that there was no real traumatic pneumonia or pneumonia from an injury or wound, but Dr. Lange has established beyond doubt from his observations that there is a traumatic pneumonia, finally resulting in an abscess. The doctor has very completely presented the subject.

Dr. J. D. Thomas—In the main I agree with all the gentleman has said. There are, however, two points of comment which I desire to make.

One is the defective logic in the statement made, if I understand him correctly, that all cases of acute lobar pneumonia depended upon the diplococcus of Frankel or they did not. We may have an acute pneumonia following a trauma; it is undoubtedly a pneumonia, but it does not depend upon the pneumonia micrococcus. The other point is, that there is a variety of pneumonia, and I have observed some six or eight of such cases, not mentioned in the paper; neither have I seen a description in any work or paper of the variety to which I wish to draw your attention. I can probably give you a better idea of the disease by describing a case. You are first called to see the patient a week or ten days after the illness began—the onset being insidious. Pain is complained of in the lung. There is fever, but not very high. There is an accelerated

pulse, but not very rapid. The temperature will be about 101 degs. Fahrenheit, and the pulse about 90. On percussion there is *flatness*; on auscultation no sounds are heard. You at first suspect pleuritis with effusion. You change the position of your patient, but no change is produced in the line of flatness; the bronchial tubes, as well as the air cells, appear to be filled with the exudate. As you follow the case the flatness passes further up the chest, and with this increased area of flatness the air sounds disappear. The process is a slow one, occupying weeks. As repair takes place the flat sound passes to dull and so on; air enters the tubes and cells, and in time you get the subcrepitantrales, but it may be a year or more until all evidence of the disease has disappeared. The signs first begin from below, and first disappear from above.

The only solution that I can give for these physical signs is, that there is an exudate filling up the bronchial tubes, as well as the air cells, thus giving the flat percussion note, and the absence of all auscultatory respiratory sounds. Pleuritis with effusion is excluded. Chronic pleuritis is usually of tubercular origin, and the prognosis bad. In these cases the prognosis is good, but convalescence tedious.

After having observed a case or two of this disease I was requested by Dr. Case to see a patient that puzzled him. Although he had been in attendance for some time he was unable to classify the disease—it was neither a pneumonia nor a pleurisy. After examining the case I recognized it as of the variety that I this evening present, and made a favorable prognosis. After a long while the patient recovered.

Dr. Buchanan—I would ask the speaker whether he made any exploratory punctures to see whether these were not cases of encysted pleuritic effusion.

Dr. Thomas—I did not, because I did not think it was necessary to do so. I did not find any evidence of pleurisy, and with effusion into the pleural sac, you would always get a change in the dullness with regard to the change of the patient. If it was pleurisy you would not get the uniform symptoms all over the lungs that you do in these cases.

Dr. Buchanan—I can understand how in cases where the lung had become adherent to the chest wall from a former pleurisy, fluid would start at the lower portion of the lung and gradually fill up, push the lung ahead of it, and give just the signs that the gentleman has spoken of. I think that view of the case would more nearly meet his description than any form of pneumonia that is recognized.

Dr. Grube—There is one statement made by the writer I would like to call attention to, and that is the statement that

pneumonias of children under eight years of age were almost always catarrhal. I know this is the older idea, and in all the older works the statement is made, but I think it is not true. It might be true between the first and second year, but certainly not between the second and eighth. I think that between the second and eighth years croupous pneumonia is more often found than the catarrhal variety. I think this older idea was obtained through not making a careful diagnosis, and from the fact that catarrhal pneumonia almost always affects both lungs.

Dr. Kœnig—I was gratified to see the non-committal stand the writer has taken with regard to the causation of what he is pleased to term croupous pneumonia. I have never been able to reconcile myself to the theory of bacterial origin. It requires but one argument to my mind to displace that theory—namely, that we can cure, that we can abort pneumonia, with remedies that have no destructive power over germs. I think there are few general practitioners here who have not seen cases of acute lobar or croupous pneumonia aborted under the influence of powerful antiphlogosis. Be it tartar emetic or aconite, or veratrum viride, no matter what the remedy may be, the action is identical. This counteracts the too great effort that nature is making in repairing damage that has been done to the lung tissue. Some years ago an article appeared in the *New York Medical Journal* on the causation of pneumonia in which a very ingenious theory was advanced. The writer claimed that pneumonia was a disease produced as a result of certain atmospheric conditions—namely, that when air was very dry it would absorb moisture from the delicate air cells very rapidly and produce a deposition of chloride of sodium which in that concentrated condition would destroy the epithelium. This theory seems to me plausible. The bacteria find a fertile soil when once the walls of the air cells are injured, and at once too much blood is sent to that very vascular part of the body, and instead of repairing the damage, nature does more damage still by the overengorgement of the lung tissue, which increases till hemorrhage into the air cells takes place. I firmly believe, in fact I have convinced myself, that if the heart's action is restrained so that just sufficient blood is sent to the lung to repair the injury, nearly every case will be cut short if treated in the first two or three days after the original injury to the air cells.

Dr. Batten—In regard to the etiology of pneumonia, the last gentleman on the floor asserted that a case of pneumonia can be controlled with drugs. Now, we all know that typhoid fever is caused by germs, and it may be said that typhoid fever



can be controlled also by drugs, but if we have a case of pneumonia in a place where the hygienic conditions are not good, as a rule the drugs which we give will not very much benefit the patient; but if we have a case of pneumonia in a place where the hygienic conditions are good, the probability is that with a little treatment the case will recover. So that this question of the germ theory would not hold in pneumonia. I believe that pneumonia is caused by a germ, and that the life of the patient will depend very much upon the environment of the patient.

Dr. Green.—I am thankful that the paper has classified pneumonias and I am thankful that they are corralled in three classes; in fact, in treating cases of pneumonia, we still meet with very great obstacles. However, I was pleased with the classification of the doctor from the fact that he seemed to be governed in the classification generally by the locality of the disorder, as much if not more than by the origin or cause of the disorder. In looking over the reports of pneumonias the mortality rates under the different treatments show no difference per centum.

Another matter of which I wish to speak is in regard to microbes giving origin to pneumonia, and also to the infectious character of the disease. Now, it is a very difficult matter for the general practitioner to decide whether or not all cases are infectious. I fully believe that the vast majority of cases are infectious, but I can not see how they are all infectious; I am unable to see from the classification given by the different writers and from the history of the cases of the epidemics of the different classes of pneumonia, that all classes are infectious. Everybody had a large number of patients, and nearly every practising physician had a very great variety under his charge, and in looking about for some reliable method, I found that by some writer, I have forgotten his name, the inhalation of chloroform was recommended. I used chloroform as often as three or four hours for three days. In this case the patient seemed to recover promptly. I also used in a few cases large doses of digitalis with good results and in one instance with a bad result. The doctor did not refer exactly to the treatment of pneumonia, but granting that pneumonia is brought about by the presence of the germs, or micro-organisms, we fail to find anywhere recorded in the recent writings a case where treatment has even modified the case to any noticeable extent. I will relate an incident: In a hospital in four of the beds were cases of typhoid fever and in the remaining bed a patient suffering from pneumonia was placed; he only lasted about forty-eight hours after his admittance. The cases of typhoid fever ranged from the tenth to the twenty-first day. Within five days

these four patients took pneumonia and three of them died. The other one was then removed and we gave the room a thorough cleaning before any other was admitted. That seemed to me positive evidence of infection. I can recall another instance of a family of five where four members of the family were taken down with pneumonia within ten days. The house was well ventilated and well heated and I think clean. That appears to me to indicate that some cases of pneumonia are very much more infectious than others, with the surroundings and the sanitation good.

Dr. Allyn—I can not keep out of my mind that pneumonia bears a certain relation to the temperature and climate. Of course there may be germs that work actively in it, but from my reading, it does seem to me that there is a causative effect produced by the climate. The paper referred to by Dr. Kœnig was written by Prof. Baker, and his tables are in the transactions of the international congress at Washington. There he has lines marking the introduction, first of the simple inflammation in the early part of the autumn, following down the air passages as the intensity of the season increases; he had his laryngitis, then his bronchitis, and finally his pneumonia. These lines correspond in a most wonderful way to the temperature of the State of Michigan where the experiments were made. We, of course, may have cold atmosphere in the fall, producing these results, but how many times do we have an atmosphere fit for the production of pneumonia? I remember on leaving college the first case I was called to—it was in the month of June—was that of a vigorous man, a cooper by trade, with lobar pneumonia of the two lower lobes of the right lung. He had contracted the disease by sleeping in a house recently plastered. There had been produced a climate which to my mind was equivalent to a late autumn climate, a depressing climate.

Dr. Christy—The question of causation of pneumonia, so far as we are concerned in America, is simplified by the statements made by the gentlemen preceding me. It is here in this country indeed a climatic disease. Those of you who are conversant with the continental population, the way in which they live, the way in which their work is done, the way in which their lives run through, know that their condition is entirely different from ours. We live in the open air here, we live on farms. Our population in the cities is not closely confined as a rule, like the population on the continent, where the people are housed in tenements and flats without ventilation, ill heated, ill lighted, with poor food and ill clothing. In this country it is purely a climatic disease. The entire subject I think is one

of renewed interest to us as medical men in the last few years since the prevalence of this epidemic which we have had. While I do not see as many acute cases as I did formerly, yet I see them where the products of pneumonia have never undergone resolution, I only heard the latter portion of the doctor's paper, in which of course he did not go into the minutia, but I think as practitioners, we are apt to overlook small portions of the lung which are involved, and while we are in charge of the case it never undergoes resolution. The case passes out of our hands, becomes a cause of irritation to the patient and may do irreparable damage. And we see more of that since the prevalence of grip than we ever did before; an almost imperceptible part of the lung not having undergone resolution and I think practitioners should be very careful in letting their patients go from under their charge until perfectly sure that every portion of the lung has undergone resolution.

The case related by our friend, Dr. Thomas, is instructive. I do not know whether I am right, but I have always considered that class of cases as beginning in the digestive tract or in the liver. Perhaps it is another class to which the doctor refers, but this is a class of cases which has given me a great deal of trouble in giving a diagnosis, and I am unable to give a favorable prognosis, not knowing how long the case will run. I think the trouble arises in the gastro-duodinal tract and gradually implicates the lung. And while perhaps not lasting as long as those Dr. Thomas speaks of, they do not get well as promptly as lobar pneumonia should get well under other circumstances, and it is a class of pneumonia which I think is too lightly looked upon. I have under my charge at the present time a case of catarrhal pneumonia which had its acute stage in February, following an attack of grip. I did not see it until midsummer. It is a case of catarrhal pneumonia, and the left lung is cleared up and the right lung does not clear up, and I do not think it ever will until the digestive tract is perfectly restored.

Dr. Lange—I am obliged to you for the kind reception accorded my paper, and would say first that I was entirely limited to the etiology and pathology of pneumonia, excluding all treatment, clinical history and symptomatology. It is common for these discussions, and I think properly, to take a wider range, but I have nothing to say of the clinical history and treatment of pneumonia, except, perhaps, that when it is remembered, as appears in the last number of the *Journal of the American Medical Association* that in a thousand cases of pneumonia treated by the three principal methods, you read to-day in the last number of the *Journal* that there is abso-



lutely no difference in result in a thousand cases of pneumonia treated by these three methods, then I think the less said about the abortion of pneumonia the better. Dr. Kœnig has said that pneumonia may be aborted by the employment of anti-phlogistics. Now, in making this assertion, it must always be remembered, as Dr. Batten has pointed out, that if this disease is caused by a germ, the grade of the disease will be in accordance with the number and virulency of the germs. A man may take a pneumonia which gets well in two or three days under no treatment, while his neighbor gets a pneumonia which is so extensive and virulent that he dies: this is the only explanation. In the first instance the man has received either a less quantity of germs or germs of less virulence than the other man, or his susceptibility to the germ is less.

This is the only explanation that can be made, and as we have no means of gauging the number of germs, nor the virulence of germs, nor susceptibility to germs, we should be very careful about claiming to have aborted a pneumonia or any other infectious disease, if pneumonia be infectious. And I think, gentlemen, the same criteria will hold for croupous pneumonia, be it the result of germs, cold or blows upon the chest. These latter are the old established causes. A fall of temperature, which is properly called a blizzard, or a rise of temperature, which is popularly called a thaw, both have a reputation of being followed by pneumonias and other inflammations of the glands and mucous membrane. Can measure the quantity of cold a patient takes no better than the quantity of germs or the virulency of germs. Again, one patient exposed to the same atmospherical changes as another, the first receiving a pneumonia as the result; the other may take a bronchitis; still another may take a tonsilitis or a coryza or rheumatism. This is a matter of personal susceptibility. Now, with our patent inability to gauge or measure the potency of all the causes of pneumonia, on the one hand, and the susceptibility of patients, on the other, how can a claim to abort pneumonia by any interference we may make—how can it hold?

The case described by Dr. Thomas, if he did not inadvertently omit to mention the signs of pneumonia, was evidently one of pleuritis. Dr. Thomas said there was absolutely nothing on auscultation over the part considered to be solidified, and that the percussion note was dull or flat. This is not sufficient evidence of pneumonia. A diagnosis between pleuritis and pneumonitis can not be made by percussion. Both frequently present the same dull or flat note. Auscultation, on the other hand, will demonstrate the absence of respiration over a pleuritic effusion, or, in pneumonia, a very great

increase of respiratory sounds, viz: bronchial breathing, broncophony, whisper, etc. If change in position of the patient did not change the level or area of dullness, then, as Dr. Buchanan has said, the pleurisy was encapsuled. I have no knowledge of any form of pneumonia in which the large bronchial tubes are filled with exudate.

The objection of Dr. Grube to the statement that the pneumonia of children under eight years is almost always catarrhal. I have no desire to refute, nor statistics at hand to serve. The doctor thinks that, excepting in children under two years of age, this inflammation is, in the majority of cases, croupous. One needs but to remember whooping-cough and measles, and their mortality in patients under eight years, this mortality being largely due to catarrhal pneumonia, to make fatal catarrhal pneumonia as frequent as croupous pneumonia is rare in patients under eight years.

The pneumonia introduced by Dr. Christy, which embraces in its etiology disturbances of the liver or stomach or duodenum. I have not met and have no knowledge of. In the case related by the doctor, where the patient was ill with pneumonia three months or longer, and where gastro-duodinal disturbances also existed, I should not rank these latter as causative of the pneumonia, but as its very natural consequences.

#### TWO CASES OF PROSTATIC HYPERTROPHY AND PROSTATECTOMY.

Dr. R. W. Stewart—I desire to present two specimens of hypertrophied prostate; and also to report a case of prostatectomy. The first specimen is one I removed from the dead-room at Mercy Hospital. In this case there was no history of urinary trouble further than a frequency in passing water, and death was due to other causes. This specimen illustrates beautifully the resulting changes due to obstruction to the out-flow of urine from the bladder, the obstruction in this case being a crescentic bar traversing the vesical orifice of the urethra. You will notice that the bladder wall is thinner than normal, and that several saccular pouches are present, caused by the yielding to the intra-vesical pressure of the bladder wall in those situations which are not strengthened by buttresses of hypertrophied muscular bands. Both ureters are dilated, the pelvis on the right side being so much so that it must necessarily interfere, to a great extent, with the excretory function of the right kidney.

A glance at this specimen will show how disastrous would be the results, should a cystitis develop in such a case, since

an extension of the inflammatory process along the dilated ureters would be almost unavoidable, and a suppurative pyelonephritis would be ushered in.

The second specimen has an interesting history. Its unfortunate possessor was a blacksmith, aged 53. About three years ago he came under my care at Mercy Hospital. At that time he was suffering from retention of urine, due to an enlarged prostate, the attack being brought on by intemperance. He recovered from this attack, and I lost sight of him until a few months ago, when he again entered Mercy Hospital, suffering intensely from retention of urine, cystitis, and the rude attempts at catheterization. His condition was evidently going from bad to worse. The urine could be only withdrawn with the greatest difficulty. He was feverish, his tongue was coated, and he was in constant agony. Nevertheless, he refused to submit to a prostatectomy, which I urged upon him, and in a few days after his admission the urine became scant and bloody, and death from suppression of the urine followed. The specimen of this case which I show you presents a typical enlargement of the prostate, the middle lobe being chiefly involved. It projects into the cavity of the bladder, acting as a ball valve in preventing the outflow of urine, and bearing on its urethral aspect abundant evidence of the rude manipulation to which it was subjected in the endeavors to force a catheter over it. The lateral lobes are also enlarged, the effect on the prostatic urethra being to convert it into a mere vertical slit of very considerable depth, the increase in the vertical diameter of the urethra rendering more prominent the projecting middle lobe, and more difficult the introduction of instrumentalities which follow the floor of the urethra. The bladder in this specimen, in contradistinction to the one previously shown, has undergone a marked hypertrophy, its caving being diminished. No sacular dilatations are to be seen, nor are the ureters dilated.

The third case I desire to speak of is one in which I performed a prostatectomy. This patient, an Italian, age 58, was sent to Mercy Hospital, on August 4, by Dr. Foster, suffering from retention of urine. On his admission, Dr. Kearns, the resident surgeon, succeeded in passing a soft catheter and withdrew a quantity of bloody urine. On the following morning attempts to pass a catheter were unsuccessful, and in the afternoon I was sent for to see him. I was unable to obtain a concise history of his case, but learned that his present condition was the culminating point of a trouble from which he had been suffering for a period of at least three months.



The bladder was distended to midway between the umbilicus and the ensiform appendix; and as the necessity for its relief was urgent, I had the patient anæsthetized and readily passed a soft catheter into the bladder, relieving the bladder of its extreme distention, but purposely not emptying it. While the most urgent symptom of the case was thus temporarily removed, the cause of the trouble, an enlarged prostate, still remained, a constant menace to the life of the patient. Under these circumstances, I decided to do a prostatectomy, choosing the perineal route. I opened the membranous urethra on a grooved staff; then pushing my index finger along the urethra into the bladder, I could distinctly feel the projection at the vesical orifice of the urethra of the enlarged middle lobe. It was about the size of a walnut, and extended further to the right than to the left side of the median line. On withdrawing my finger, about an ounce of urine gushed out, the flow being suddenly checked by the apposition to the vesical orifice of the urethra of the middle lobe. With a bone scoop I detached one side of the tumor sufficiently to enable me to insinuate my index finger between it and the body of the prostate, and by this means tore it from its attachments and readily removed it.

A microscopical examination showed it to be prostatic tissue. About half an inch of the prostatic urethra which was attached to it was also removed. This portion of the urethra was torn by the passage of the catheters, and was doubtless the source of the bleeding, which had been a marked feature of the case. The hemorrhage from the wound, while persistent, was not profuse, and was checked by the internal administration of ergot and the tincture of the chloride of iron. The urine drained through the perineal opening for about three weeks, when the patient was discharged from the hospital. Since that time it has all passed by the natural way, and, except for a slight difficulty in retaining the urine when the bladder is full, the patient suffers no discomfort. As the latter condition is steadily improving, I expect that it will ultimately disappear.

The subject of prostatic hypertrophy is, from its frequency, of interest to the general practitioner as well as the surgeon. Sir Henry Thompson states that one-third of those who have reached the age of fifty-five are affected by it, but that only one-half of those affected require treatment.

Why the prostate should become enlarged is an obscure subject on which but little light has been shed, and we have no better explanation to offer than has the gynecologist to explain why its analogue in the female uterus should undergo similar changes at middle life.

The explanation offered by Hornson, that it was the sequence of increase frequency in passing water, can not be accepted, since it never occurs before the age of fifty, even with an irritable bladder. In a case which I reported to this society one month ago the patient, from the age of eleven to twenty-one, passed water from twenty to forty times a day, yet in this case there was no enlargement of the prostate. The earliest manifestation of an hypertrophied prostate is a frequency of passing water, noticeably at night, or in the early morning, differing in this respect from the frequency of passing water where a calculus is present. The frequent urination observed in prostatic hypertrophy is due to the fact that the bladder is incapable of emptying itself. The amount of residual urine remaining in the bladder varies in different cases. Thompson reports a case where he removed six pints of urine, the patient fancying at the time that his bladder was empty. I recently removed twenty ounces in a case where I had the patient urinate before me, and he likewise assured me that his bladder was empty. Why the bladder does not empty itself under these circumstances is probably due to two factors, an atonic and weakened condition of the bladder, weakening its expulsive power, and a difficulty in opening the vesical orifice of the urethra from the increase in the development of the surrounding muscular tissue. The result being that the detrusor fibers of the bladder are only able to maintain a patency in the vesical orifice of the urethra when aided by the intravesical tension. When the latter is relieved by the escape of a definite amount of urine the efforts of the former become impotent and urination ceases.

The treatment of this condition requires the judicious use of a catheter and the treatment of cystitis if present. In those unfortunate cases where there is retention of urine the case assumes a serious aspect, and may tax the patience and ingenuity of the surgeon to the utmost. Only flexible instruments should be used—the best and most often successful being the common soft rubber catheter. If this should fail, the condee catheter of Mercier should be tried. The long curved silver catheter should be avoided, as it will rarely pass where a soft instrument fails and may do considerable harm. The linen catheter manufactured by Lee, of Philadelphia, have a very defective coating, which softens if retained for a few minutes within the urethra and are rendered useless; besides the tip of these catheters is not flexible enough for easy introduction into the bladder. Where retention of urine becomes a marked feature and catheterization is difficult, the propriety of removing the obstructing portion of the prostate should meet with favorable consideration.

Dr. Murdoch—I know of no more instructive case than the one Dr. Stewart has just described, and I feel that he has gone over the subject so thoroughly and so well that there is little left to say. I fully concur with him in most of what he has said, if not all. These certainly are cases that come under our daily observation, and to know how to manage them is something that does not at once occur to us all, and we may do, as Dr. Stewart has said, great damage to an old man by attempting to relieve his bladder where he is suffering, with a solid instrument. An old gentlemen of seventy is now under my care, who was taken with retention in the night and sent for a practitioner, and with just such an instrument as Dr. Stewart has condemned, he made a false passage in the old man's urethra. Now, the kind of catheter to be used can not be too highly emphasized, and there is probably no catheter which will reach more cases than the one Dr. Stewart refers to, the old fashioned English catheter, or the soft rubber catheter, a very long one. It will follow the circuitous route of the urethra better than any solid instrument can. I do not say there can be no case in which a silver catheter would not be better, but as a rule the soft catheter should be used. There is one thing I want to say in addition to what Dr. Stewart has said. Dr. Stewart said he did not draw off all the water from this old gentleman's bladder, but that he concluded to remove the remainder of it at another time. Now, I consider it of great importance that every one should know it would be very bad to empty the bladder at one time, and Dr. Stewart's plan of drawing off a portion of the water should be followed, a week, perhaps, being taken before getting the bladder down to its normal size. I have considered it of the greatest benefit where there is a great amount of atony, to teach these old gentlemen how to use the soft catheter. They usually get up in the night for the purpose of making water. If you can teach these old gentlemen how to relieve their bladders they will be able to get four or five hours' rest. In a great many cases I think it is better to teach these men how to use the catheter and advise them to use it continually, giving up the idea of passing the water naturally, but to drain it off at regular intervals with a soft catheter.

Dr. Thomas—I have had patients come to me who had had a catheter introduced into their bladder when there was no occasion for such treatment. If a silk catheter is left in the urethra for a few hours, there is danger of the covering coming from it, but a soft catheter may be left in for days and days.

Dr. Buchanan—I wish to come to the rescue of the silver



catheter. A very large proportion of the cases of prostatic enlargement which are seen by the surgeon and require evacuation of the urine can be reached readily and easily by the long beaked silver catheter, a specimen of which was exhibited here to-night, and in these cases there is to my mind nothing to equal this smooth, hard, inflexible instrument. Now, I know there are other cases where a flexible instrument is the safer, and of course we ought to resort to it in such cases. But to any one who has been called to see patients where the catheter must be inserted repeatedly for days, perhaps for weeks, as I presume we all have, I think the silver catheter will recommend itself. It is my experience that an old man will ask, if he has choice of the methods, that a silver instrument be used rather than any silk or rubber one, on the ground that it causes less irritation. For this reason, I think we should use the silver catheter. And in addition it is very much more easily rendered aseptic.

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#### ADAMS COUNTY MEDICAL SOCIETY.

The Adams County Medical Society held its regular monthly meeting at the offices of Dr. N. L. Guice, Natchez, on Tuesday, October 13, 1891.

Dr. Guice presided.

Dr. H. L. Metcalf handed in his application for membership and was accepted by a unanimous vote.

Dr. P. Beckman read a paper (see original article, page 321) on Multiple Ligation of Varicose Veins of the Legs, which was discussed by the members present.

The President thought the mode of operation urged by Dr. Beckman was the proper course to pursue and offered the best results.

A motion was made by Dr. W. A. McPheeters that a committee of three, to which the president should be added, be appointed by the chair to draft a fee bill and report at the next meeting. The motion was seconded by Dr. B. D. Watkins, and was carried. The chair appointed on that committee Drs. L. H. Lamkin, B. D. Watkins and W. A. McPheeters.

Meeting then adjourned.

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EXPERIMENTS WITH POISONS.—By way of a sequel to the paper recently read by Dr. Cornil before the Academy of Medicine, concerning the experiment made by a foreign doctor, which consisted in grafting a cancer from the breast of one

woman to that of another, Dr. Ch. Daremberg gave, last week, an interesting account of the practice, so common in the Middle Ages, of experimenting with poisons on condemned criminals. He mentions the two malefactors made over by Como de Medicis to Falloppé of Pisa, who administered to each a dose of six grammes of opium. The one who survived was pardoned, but the scientist administered a second dose of the same quantity, which killed him. At Bologna the criminals experimented on were not informed of the fact, as terror might heighten the effects of the poison, and false conclusions be deduced. At Mantua and Florence, arsenic was administered to human beings; the Cardinal Archbishop of Ravenna, Pope Clement VII, made tests, generally unsuccessful, of remedies for aconite, corrosive sublimate, etc. At Paris, Charles IX invited Ambroise Paré to testify to the anti-toxic action of bezoar; the man died in terrible agony from poison, despite the supposed antidote, saying he would have preferred the gallows a thousand times. Dr. Daremberg cited, in conclusion, the numerous inoculations and injections made in more recent times, principally with regard to syphilitic disorders. He stated that between 1831 and 1837, Dr. Ricord re-inoculated 1049 persons (suffering from simple non-syphilitic chancre) with a soft chancre. Lindsmann inoculated 2200 people in the same way. Many doctors, introducing new remedies—like Jenner and Koch—prove their faith in their treatment by submitting to them personally. Rabuteau killed himself in testing new medicaments.—*Bulletin of Pharmacy.*

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## Editorial Articles.

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### DR. McLAUGHLIN'S THEORY OF IMMUNITY.

The letter of Dr. Wm. Moor, in our last issue contained an inaccuracy which Dr. McLaughlin corrects in the following communication:

*Editor New Orleans Medical and Surgical Journal, New Orleans, La.:* DEAR SIR—Dr. Moor, in his recent communication to the NEW ORLEANS MEDICAL AND SURGICAL JOURNAL makes certain statements regarding the subject matter contained in an article on "Immunity and Contagion,"\* which are so completely at variance with the utterances of that paper that I deem it necessary that these errors of statement should be pointed out and corrected. Another and more personal reason for this correction is to relieve myself of the unjust charge which Dr. Moore makes against me of having appropriated Chauveau's theory of immunity as my own discovery.

The following quotations from the respective papers speak for themselves.

Dr. Moore, in the communication referred to, says: "Though very much admiring the doctor's stylistic faculties, still I am obliged to say that his theory is virtually the one ad-

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\* "An Explanation of the Phenomena of Immunity and Contagion, Based Upon Physical and Biological Laws." By J. W. McLaughlin, M. D.



vanced by Chauveau, which attributes the acquired immunity to substances resulting from the body-metabolism of the respective micro-organisms, and held in solution thereafter by the previously infected body."

Now, that which the doctor calls "the substances resulting from the body-metabolism of the respective micro-organisms" are the substances ordinarily termed ptomaines. They are the products of bacterial action, and it is to the ptomaine of a given bacterium that Chauveau ascribes the acquired immunity from the disease of which this bacterium is the cause. This hypothesis assumes that the ptomaine must permanently reside in the blood or other tissues of man's body, in order to give him permanent immunity from the disease.

The following quotations from my paper show that this is not the theory of immunity of which I claim authorship :

"How does one attack of an acute infectious disease give man immunity from other attacks of the same disease? is the question that now offers itself for solution. A bacterium cell disrupts molecular combinations of the albuminoids when the molecules of each vibrate in the same periods of recurrence: the albuminoid molecules which are thus disrupted, shaken apart, liberated from their chemical bonds, will again immediately recombine, because of their chemical affinities, to form other combinations called ptomaines. Explanation has been made why these ptomaines will have molecular vibrations, which will interfere with those of bacterium, and when this substance accumulates in sufficient amount, its molecular vibrations will antagonize, inhibit those of the bacterium, and thus arrest its power of converting albuminoids into ptomaines.

\* \* \* \* \*

"Now as the molecular vibrations of the bacterium must coincide in periodic time with those of the albuminoid it disrupts, it follows that a ptomaine will interfere with, inhibit both substances alike, *i. e.*, when the molecular vibrations of two substances recur in the same periods of time, a third substance that would interfere with one of these would interfere with both alike. Hence the ptomaine which interferes with the vibrations of its bacterium will also interfere with the vibration of that molecular combination which the bacterium

can disrupt. Now this interference or inhibition of the ptomaine with the albuminoid causes a change in its molecular vibration. As this is an index to and a result of molecular combination or structure the albuminoid becomes changed in its molecular structure. As long as the molecular structure of the albuminoid remains thus changed it could not be influenced by the molecular vibrations of the bacterium, could no longer be disrupted by it, and consequently is immune from the disease of which this bacterium is the cause.

*“Ptomaines are chemical substances and do not find in man's body a permanent abiding place; like other chemical substances they are eliminated in a reasonably short time.*

“How then are we to explain the more or less permanent immunity which observation and experience teach us is secured by the various artificial means which have been referred to? How are we to explain the fact that the phenomena of interference manifested as change of molecular movement in certain albuminoids of the blood persist more or less permanently after the interfering cause, the ptomaine, has been eliminated?

“The change in molecular structure of the albuminoid, which the ptomaine has imposed upon it, and which enables it successfully to resist the molecular bombardment of the bacterium to which it had previously been vulnerable, this theory claims is more or less permanent and is a process allied to that by which bacteria become ‘attenuated.’ Now it is well known that many varieties of bacteria, both ferment and pathogenic, can be attenuated, that is weakened in their power of producing specific products. Thus the yeast cells—*saccharomyces cerevisiae*—will, when attenuated, grow and flourish in grape juice or brewers' wort without producing a particle of alcohol; the *bacillus acidi lactici* will grow and reproduce in watery solutions of alcohol without producing vinegar; and the pathogenic bacteria will grow and thrive in suitable food media without producing their respective ptomaines. The process of attenuation need not be complete; it can be arrested at any stage, so that the capacity a bacterium has of producing its ptomaine will depend upon its degree of attenuation.”

Attenuated bacteria are morphologically identical with

those not attenuated; they present the same appearance and reproduce themselves as rapidly as do those not attenuated, and what is most remarkable, a bacterium once attenuated will transmit this change to its progeny through heredity.

Now if the specific power of producing specific products which bacteria manifest is caused by their respective molecular vibrations, as this theory claims them to be, attenuation of bacteria would be a change in their molecular structure as molecular vibration. Molecular structures are so closely associated that a change in one can be made only by causing a change in the other; this at least is the teaching of spectrum analysis.

If, now, the change in molecular structure which a ptomaine will impress upon its associated albuminoid is a process similar to that of attenuation, we are prepared to understand why this change may be more or less permanent by transmission through heredity from albuminoids to albuminoid, and thus give immunity from that disease of which the bacterium was its cause and the ptomaine its product.

Immunity, then, as explained by this theory, is caused by a change in the molecular structure of the albuminoids imposed upon them by the ptomaines, which are regarded as interfering bodies capable of inhibiting bacteria in their specific work and of changing the molecular structure of albuminoids, a very different theory from that championed by Chauveau, which assumes immunity to be the direct result of ptomaines and demands that these substances shall permanently abide in the body of the previously infected individual.

J. W. McLAUGHLIN.

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#### POST-GRADUATE INSTRUCTION IN DISEASES OF THE EYE, EAR, NOSE AND THROAT.

Beginning with November 21, 1891, courses of instruction, lasting for six weeks, will be given at the Eye, Ear, Nose and Throat Hospital, New Orleans. The courses on diseases of the ear, nose and throat will be given by Drs. A. W. de Roaldes



and A. McShane; those on the eye, by Dr. S. D. Kennedy. The vast amount of clinical material offered by this institution presents the greatest variety of morbid manifestations. Over three thousand patients are treated annually. The hospital is provided with a complete and modern armamentarium. The opportunity here offered for the study of special diseases is unsurpassed elsewhere in this country; and in a brief period one is enabled to become practically familiar with the majority of the diseases encountered in daily practice.

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#### INDEX CATALOGUE OF THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE.

The twelfth volume of this stupendous compilation has been received. Though only a work of compilation, it involves a vast amount of labor; and those engaged in its production deserve great praise for the thorough manner in which their work is done. These volumes are issued at long intervals, during which many contributions have been received; the titles of this new matter will fill probably five volumes.

The present volume is of special interest to us, since it contains a list of the works of the late Dr. H. D. Schmidt, pathologist of the Charity Hospital, to whom many of the younger physicians of the southwest are indebted for their introduction to the microscope in medicine.

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### Abstracts, Extracts and Annotations.

#### SURGERY.

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##### STAB-WOUNDS OF THE SPINAL CORD.

Dr. Otto Bode (*Berliner klinische Wochenschrift*, Jahrg. xxviii., No. 22) gives an interesting account of the diagnosis,

course and proper treatment of stab-wounds of the spinal cord. He cites the case of a man who, in a street fight, received several wounds on the head; on the back of the neck there was one about five centimetres long, running obliquely down to the spinal column and exposing at its bottom the atlas and axis. At the moment of wounding the patient fell to the ground, lost consciousness for only a minute, but remained paralyzed on the right side below the point of wounding. When called upon the right lower extremity responded slowly and reluctantly, but for walking or standing was weak and useless. There were no areas of anæsthesia, nor any disturbance of the special senses. The bladder and rectum were normal; priapism not present. The muscles of respiration on the right side were decidedly implicated. The faradic excitability of the muscles remained normal. For three weeks this condition continued apparently unaltered. At the expiration of this time the patient began to gain more and more use of the paralyzed limbs, albeit at the same time the reflexes became greatly exaggerated, and at the least touch the muscles jerked. The patient was under observation for three months: the paralysis was practically gone, and even the reflexes had returned to normal, and in a year's time no evil effects of the wound remained, save at times a slight tremor in the muscles which had been paralyzed. The wound was treated solely by the antiseptic dressings.

From the anatomical relations of the vertebræ and their ligaments, Dr. Bode proceeds to show that in the cervical region when the neck is bent down, as it usually is when a man receives a wound there in a fight, the cord can be wounded at almost any point of its circumference, or indeed, may be wholly severed, without injury to the vertebræ. From the motor disturbances and the direction of the external wound in his case, he diagnoses a partial severance of the anterior column and the anterior part of the lateral column on the right side. Therefore, he maintains that it is not possible that the lateral columns in the cervical cord carry both sensory and motor fibers, since in his case there were absolutely no disturbances of sensation.

Dr. Bode cites several cases of perfect healing of wounds of the spinal cord involving not quite half its diameter, which were recognized during life to be wounds of the cord, or were subsequently clearly demonstrated at the autopsy by the cicatrices.

He goes on to explain that the appearance of symptoms which set in generally on the second to the third day after the wounding, and which might easily be mistaken for traumatic

myelitis, is due to what Schiefferdecker describes ("Ueber Regeneration, Degeneration, und Architektur des Rückenmarks," *Virchow's Archiv*, Bd. lxii.) as traumatic degeneration following wounds of the spinal cord, and setting in on the second to the third day. The degeneration begins as a disintegration of the elements of the nerves into glossy flakes. This process extends from the cut surfaces about four to six millimetres above and below. Hence, in the case of wounds in the neighborhood of the fourth cervical vertebra, although the phrenic nerve be not at first implicated, yet at the end of the second or third day that complication may arise.

The increase of the reflex excitability, Dr. Bode explains as due to what Schiefferdecker describes as secondary degeneration, which manifests itself about the fourteenth day, and which, by cutting off the influence of the reflex inhibitory fibers running down the lateral columns in the cervical cord, gives rise to an increase in the reflexes. Schiefferdecker describes a third form of degeneration, which he calls cavity formation, and to this Dr. Bode ascribes the fibrillary tremors in the limbs formerly paralyzed.

Retention of urine and feces is not uncommon following wounds in this region. The organs either return to normal, or else incontinence sets in. The height of the wound has no influence hereon. Priapism almost always occurs where there is vasomotor disturbance. Elevations of temperature are not found on the anæsthetic areas of the skin, if there be any, but only on the areas where there is motor paralysis. This proves that the vascular nerve-supply runs down the same paths as the motor fibers. Dr. Bode cites a very interesting case where he found variations of temperature of the affected part entirely independent of the temperature variations in the rest of the body.

He maintains that it is impossible to locate with absolute certainty the position of the wound on the cord from the symptoms, since some hemorrhage affecting the parts immediately adjoining is inevitable, and, furthermore, unless the assailant's knife be very sharp, it must make more or less of a contusion on the cord before it cuts through the elastic pia mater.

To sum up, the most conclusive symptom is a sharply defined paralysis below the point of wounding, coming on at the moment the wound is received.

As to treatment, he says the external wound should be enlarged and left open. Above all, free drainage should be encouraged, even to the loss of meningeal fluid, and the blood and secretions of the wound should be kept aseptic. Finally, the wound should be allowed to heal by granulations, or sewn up secondarily.—*American Journal of Medical Sciences.*



UNION OF THE DIVIDED ULNAR NERVE BY PLASTIC  
OPERATION.

Dittel (*Wiener klin. Wochenschr.*, Jahr. iv., No. 18) reports a successful plastic operation upon the ulnar nerve, although there was considerable loss in the continuity of this structure. The patient received a severe wound of the arm, which, together with extensive injury to the skin and muscles, destroyed about two and a half inches of the ulnar nerve. The peripheral end of this nerve could not be found. The wound was closed under antiseptic precautions. Examination on the following day showed that the sensibility of the skin supplied by the ulnar nerve was practically unimpaired, and that there was very slight difference in the muscular power of the right and left arm. This was evidently due to nervous anastomosis. Four weeks later an electrical examination showed that the muscles supplied by the ulnar nerve were completely paralyzed. By no form of current could contraction be induced. An operation for the restoration of the continuity of the nerve-trunk was at once undertaken, since it seemed desirable to accomplish this before marked degenerative changes could set in. By careful dissection the proximal and peripheral ends of the nerve were exposed. About three inches from the extremity of the peripheral nerve-end a thin-bladed scalpel was thrust directly through the center of its trunk; by carrying the blade upward the trunk was split in two equal halves. The cision stopped short before reaching the extremity of the nerve. In a similar manner the proximal end was split. By transverse cuts half the nerve was freed and carried upward from the distal end, downward from the proximal end, until the extremities of the ends thus split off were brought in contact. Sutures were applied. To cover the large defect of the soft parts resulting from the original injury, a flap of skin was transplanted from the upper portion of the arm. Suppuration set in. The wound was dressed by the open method. Eight weeks after operation an electrical examination was made as to the condition of the muscles supplied by the ulnar nerve. The results were negative. Two weeks after this, however, the muscles reacted to electricity. At the time of reporting the case contractions could be excited, not only by application of the current to the muscles, but also by excitation of the nerve-trunk.

Brenner (*Ibid.*) also reports a successful neuroplastic operation ten years after injury to a nerve.

The patient exhibited a bluish discoloration and decided emaciation of the left index and middle fingers, the nails of which were thickened and turtle-backed. Both fingers were

flexed at the metacarpo-phalangeal articulations: tendons and joints were found to be normal on manipulation. The palmar surface of both these fingers and the ulnar surface of the thumb were completely anæsthetic: the other portions of the skin of the hand were normal. Ten years before, the patient had received a stab-wound on the flexor surface of the wrist-joint. The scar of this wound lay directly over the course of the median nerve: beneath it there was a hard knot the size of a cherry: this often occasioned great pain. It was diagnosed as a neuroma, and excision was determined upon. On dissecting this tumor free, it was found attached to the extremity of the central portion of the median nerve. On dividing this connection, the cross-section of the nerve seemed perfectly healthy. It was then determined to find the distal end of the nerve and restore the continuity of this structure by a plastic operation. The two extremities of the nerves were split almost to their terminations. The halves of the split trunk were freed at the points most distant from the terminations of the nerve: the flaps thus formed, made long enough to completely bridge the gap existing between the nerve-ends, were turned down and up, respectively, and were sutured to each other and to the freshened extremity of the two nerve terminations. The wound was closed, and healed by primary intention. Two weeks after operation there was return of sensibility. A year later sensibility was completely normal, and the contracture of the fingers was no more observable. The trophic disturbances, however, did not disappear.—*American Journal of Medical Sciences.*

## MEDICINE.

### THE NUTRITIVE VALUE OF RECTAL INJECTION OF EGG ALBUMEN.

The assertions of Voit and Bauer and Elchorst, to the effect that egg albumen is absorbed by the rectum only in the presence of a certain proportion of chloride of sodium, but is returned unaltered with the fæces if this reagent be absent, has led the author to investigate this point anew, and to make his observations on man, and not on dogs, as his predecessors had done. The experiments were planned with great care, and the quantity of albumen removed from the body, both by the urine and the fæces, was estimated. As the outcome of

several series of experiments, the results of which show a great agreement, Huber gives as his conclusion that egg albumen simply beaten up is absorbed by the rectum, but only in very small quantities, and consequently a nutrient enema of this kind possesses hardly any value. When, however, a certain amount of common salt is added (fifteen grains to each egg in the present series of experiments), the quantity of albumen absorbed is doubled. Peptonized egg albumen was absorbed in very slightly greater proportion than that treated with common salt. Of the albumen thus treated with salt, between 60 and 70 per cent. was absorbed, and we, therefore, have in this mixture an extremely valuable material for nutrient enemata. In no case of Huber's were the enemata expelled; nor was albuminuria ever found to occur after their use.—*Medical Chronicle.*

#### THE MODERN TREATMENT OF SYPHILIS.

As regards the treatment of syphilis, mercury was now almost universally recognized as the best remedy for it, except in Scotland. As regards the latter, Mr. Hutchinson remarked that he thought some of his worst cases came from that country. The methods of using mercury were the internal and external. Inunction and fumigation were the most efficient measures of application for cases in which the other methods are not suitable, but for all ordinary cases the administration by the mouth is the most convenient. The gray powder is the best form to prescribe; it may be given in one-grain doses, with one grain of Dover's powder, three times a day. The frequency of the dose should be increased, not the dose itself, when further effect was desired. Simplicity in prescribing is everything to those busily engaged in practice. The mercury should be given before the appearance of the secondary symptoms, and it usually prevented the onset of the latter. Is mercury a specific for syphilis? Mr. Hutchinson considered that it certainly was, and that it killed the particulate virus upon which syphilis depends. In nine cases out of ten this treatment was probably successful in preventing secondary manifestations. Idiosyncrasy as to mercury, showed itself in two ways, those in whom it acted as a poison, and those in which it failed to act. Those who are very susceptible can usually be suited by reducing the dose sufficiently.

Iodide of potassium is of very little use in the secondary stage of syphilis. The iodides of mercury are much less satisfactory than the gray powder (hyd. c. cret.). When



sores are present in the tonsils, mercury may irritate; in these cases the latter drug should be reduced, and iodide of potassium given in mixture separately. As regards phagedæna, the main point was to treat it efficiently locally, giving possibly opium internally. Iodoform is the best local measure, and since the introduction of this drug far less severe results of phagedæna had been witnessed. Cauterization with the acid nitrate of mercury may also be employed. Some of the worst forms of phagedæna occur during a second attack of syphilis.

A course of mercury should last over a long period; six months to a year. The long course usually does the patient's general health good. A minority are made irritable and susceptible to colds. Such benefits are sometimes derived from the drug, that one patient had exclaimed to Mr. Hutchinson, "Before I had syphilis my life was a burden to me." It is a valuable remedy also for dysmenorrhæa, and many forms of chronic inflammation.

Does the apparent cure of syphilis by mercury place the patient in a better position as regards the tertiary manifestations? Mr. Hutchinson stated that it was extremely difficult to decide definitely on this point by any statistics, pointing, however, strongly to the conclusion that it did so, was the fact that the severe forms of syphilis were becoming less frequent year by year. The bad cases of bone disease, periostitis, etc., were much less often seen now.—*Med. Press and Circ.—Times and Register.*

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#### HYDRASTIS CANADENSIS.

From a physiological and therapeutic study of hydrastis Dr. Cerna (*The Therapeutic Gazette*) has arrived at the following conclusions: 1. Hydrastine is poisonous to both cold- and warm-blooded animals. 2. The minimum fatal dose of the drug in the common frog (*R. esculenta*) is 0.001 gramme for every thirty grammes of the animal's weight. 3. The minimum fatal dose of the alkaloid in the dog, by hypodermic injection, is 0.50 gramme for every kilogramme of the body weight. 4. Hydrastine destroys the irritability of the muscular tissue. 5. The alkaloid likewise destroys the excitability of the efferent or motor nerves. 6. Very large quantities produce loss of the functional activity of the efferent or sensory nerve-fibers, and also cause anæsthesia when locally applied. 7. Hydrastine, in small amounts, increases reflex activity by stimulating the spinal cord. 8. Later in the poisoning, by large quantities, hydrastine diminishes reflex action by stimu-

lating at first Setschenow's center in the medulla oblongata, and afterward abolishes it by paralyzing the spinal cord. 9. The paralysis produced by the drug is due to an action upon the muscles, the motor nerves, and spinal cord. 10. The convulsions of hydrastine are of a spinal origin. 11. Hydrastine destroys the electro-excitability of the cardiac muscle. 12. The alkaloid, in small doses, produces a primary frequency in the pulse-rate, due probably to a stimulating action on the cardiac motor ganglia. 13. In moderate and poisonous amounts it diminishes the number and increases the size of the cardiac beats by an action upon the intracardiac ganglia and the heart-muscle itself. 14. Hydrastine lowers arterial pressure by a direct action on the heart, and also through a paralyzing influence exercised upon the centric vasomotor system. 15. The drug produces at first an increase, and afterward a decrease, in the number of the respiratory movements. 16. Hydrastine kills by failure of the respiration. 17. The alkaloid lowers bodily temperature. 18. The drug increases peristalsis. 19. In hydrastine-poisoning the salivary and the biliary secretions are largely increased, especially the latter. 20. Hydrastine locally applied produces at first contraction of the pupil; afterward dilatation of the same.

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#### A RARE ANTIPYRINE RASH.

Veiel describes a case of a patient in whom antipyrine always produced a peculiar skin rash. Soon after the dose was taken there was severe itching of the palms of the hands, the lips, the soles of the feet, and of the glans penis. The lips became œdematous, and large bullæ formed on them; two bullæ also formed on the hard palate and between the toes. On the soles and palms there were deep-red urticaria-like spots with sharp contours, which itched severely but did not form bullæ. The itch lasted three or four days; the bullæ on the lips dried in four or five days; those in the toes in about eight days; the spots on the palms, soles and glans penis desquamated in large scales after about ten days, and had vanished in about three weeks.—*British and Colonial Druggist*.—*Medical Record*.

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#### TREATMENT OF CHYLURIA BY THYMOL.

Two cases are reported, in which the filaria sanguinis was found, where complete cure followed the internal use of thymol. The first case was that of a man 20 years of age. The urine was white. Quinine and many other remedies were

tried without any result; the urine remained milky and the patient's fever continued. Thymol was given every four hours in doses of five-sixths of a grain. Fifteen days later the dose was doubled. A month after this treatment the patient was cured and no more filaria were found in the blood. The other patient was relieved under the same conditions after a month's treatment, taking the same dose three times a day.

These two cases suggest that the thymol destroys these organisms in the blood and in the tissues. The author has tried the effects of thymol upon other pathological organisms, such as the bacillus of tuberculosis and of leprosy, but without any result.—*Bulletin generale de Therapeutique, 1891.—American Journal of Medical Sciences.*

#### IN ACUTE BRONCHITIS.

A simple expectorant mixture in acute bronchitis is:

℞.—Ammon. muriat..... ʒss.  
Mist. glycyrrhiz. comp..... ʒiv.—M.  
Sig.—Take a dessertspoonful every four hours.

The dose is smaller in the extremes of life, and in severe coughs it is given every three hours.

Tablets of the muriate of ammonium and the compound licorice mixture are very efficient. When the secretions are with difficulty brought up, the use of senega is advised.

When the secretions are abundant and not easily coughed up, turpentine in emulsion is an excellent remedy, not so pleasant, perhaps, as terebene or terpine hydrate, but rarely failing to do good in properly selected cases. The formula, with occasional modifications to suit particular cases, is:

℞.—Ol. terebinthin ..... ʒij. to ʒiij.  
Mucil. acaciæ..... q. s.  
Aq. cinnamomi ..... ʒj.  
Aqua ..... q. s. ad ʒvj.—M.  
Sig.—A tablespoonful in a little water every four hours.

Oftimes the cough is of such an irritating character that these ordinary expectorant mixtures avail little; then recourse must be made to a narcotic in some form. Codeine, a very useful alkaloid of opium, has the advantage of not constipating as much as morphine. A good combination is:

℞.—Codeinæ sulphat..... grs. viij. ✓  
Syr. prun. Virginian..... ʒij.—M.

Sig.—A teaspoonful in a little water three or four times a day and at bed time if necessary.

—*Therapeutic Gazette, July, 1891.*



## OBSTETRICS.

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### DEEP MEDICATION IN THE TREATMENT OF POSTERIOR URETHRAL CATARRH.

Dr. Edward L. Keyes read a paper on this subject. Posterior urethritis, he said, had now become very generally recognized by specialists and its management much simplified. Still, among the profession at large there existed much ignorance and misconception on the subject. As a matter of fact, the treatment was easy and did not call for expert skill in the use of instruments. The author then elaborated carefully the salient points in the various conditions of the male urethra likely to give rise to intractable discharges, especially those morbid secretions having their origin in lesions situated in the posterior urethra, taking the ground that these latter were constantly overlooked by even the best men, and that patients suffering therefrom would wander from physician to physician without the true cause of their suffering being recognized, or at any rate without proper treatment for their condition being instituted.

Dr. Keyes detected posterior urethritis as follows: He "milked" the urethra, by pressure, firmly with the finger from the perineum forward and then caused the patient to urinate into two separate conical glasses. If there was posterior urethra of mild grade, the first urinary gush would contain free pus in a quantity disproportionately great when compared with what had been milked out at the meatus by digital pressure. If the grade of posterior urethritis was high, the second urinary flow would also contain free pus. If the latter had come from a prostatic abscess or a suppurating seminal vesicle, this might be demonstrated by making the patient urinate in three parts—one to wash the prostatic sinus, a second gush to show relatively what proportion of pus had flowed backward into the bladder, and here milking the prostate or the suspected vesicle by a finger in the rectum; then a third urinary gush to show what, if any, excess of pus or prostatic or seminal matter had been added to the urine by the rectal manipulation, a point to be settled by the microscope. Sources of pus from the bladder or from the kidney were omitted from consideration in the paper.

For the treatment of the condition there were certain substances which might be injected into the deep urethra when once the disease was recognized, which would have a direct local effect without subjecting the patient to the danger of

cystitis or to any of the consequences of ordinary injections or the use of sounds, and would save him from the necessities of treatment by the knife. The instrument used by the speaker was the Keyes syringe, and with it twenty minims could be thrown in so that the injection would flow through the prostate and into the bladder without any of the fluid returning. He was in the habit of using four substances—sulphate of thalline, glycerole of tannin, sulphate of copper, and nitrate of silver. The thalline was bland and unirritating. He made use of a solution of 3 to 12 per cent. in water. Of the sulphate of copper he used a 10 per cent. solution in glycerin. The glycerole of tannin was too thick to use pure, and required from 25 to 75 parts of water to thin it. The nitrate of silver he used in a 10 per cent. solution, though rarely employing it, especially in catarrhal cases. By the use of these four solutions the speaker emphatically stated that the greatest advantage might be obtained in cases which were properly diagnosed as posterior urethritis. Without these remedies he should be tempted to give up the treatment of this affection, and, when they failed, he believed the mistake in diagnosis was obvious.

The speakers who discussed Dr. Keyes' paper in the main approved his methods of diagnosing the location of the morbid process, differing with him only as to the therapeutic agents and instruments according to individual experience. —*New York Medical Journal*.

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#### ELEVATION OF THE PELVIS AS A MEANS OF RELIEVING VOMITING OF PREGNANCY.

BY SIR JAMES GRANT, M.D., Consulting Physician General Hospital, Ottawa, etc.

In 1877 I was called to attend a lady in her first pregnancy, about the third month of utero-gestation. I learned that for fully ten days she had been unable to take food, and with great difficulty retained even the smallest quantity of liquid nourishment. Almost every form of treatment had been tried without any apparent good result. As a last expedient, I decided to test the effect of elevation of the pelvis, which was accomplished by lowering the head and thorax, and placing several pillows under the sacrum. In a short time the change for the better was encouraging, and continuing the position at intervals for a few hours, in two days the marked improvement in the system was quite evident, and utero-gestation proceeded to the full term without any return of this abnormal condition.

Within the past month, two cases of severe vomiting in

early pregnancy came under observation, in both of which I adopted the same treatment, with equally satisfactory results.

Guémot, referring to the rational treatment of vomiting during pregnancy, says that a morbid or abnormal state of the uterus, the nervous system, as the carrier of reflex action, and the stomach, are the prime factors in the malady. The idea of Smellie's, that the complaint is "chiefly occasioned by fullness of the vessels of the uterus," certainly is most rational. The elevation of the pelvis gradually lessens the quantity and force of the blood in the uterine vessels, and thus reduces the quasi-irritability, or, as Dr. James Stewart, of McGill, terms it, "the instability of the nerve elements" in the uterine nervous system, the abnormal influence of which, prior to the change of the pelvic position, had been rapidly telegraphed to the spinal and gastric nervous centres.—*Montreal Medical Journal*.

## Book-reviews and Notices.

*A Treatise on Pharmacology and Therapeutics.* By John V. Shoemaker, A. M., M. D., Professor of Materia Medica, Pharmacology and Therapeutics in the Medico-Chirurgical College of Philadelphia, and Member American Medical Association, and John Aulde, M. D., Demonstrator of Clinical Medicine, and of Physical Diagnosis in the Medico-Chirurgical College of Philadelphia, and Member American Medical Association. In two volumes. Volume I. Philadelphia and London: F. A. Davis, Publisher, 1889.

Volume I, is devoted to pharmacy, general pharmacology and therapeutics. A large amount of space is given to electrotherapeutics, and very wisely, for many medical men who are familiar with the theory of electricity, and its various laws, find themselves at a loss when it comes to applying this knowledge to the treatment of disease.

The article on prescription writing is instructive and of practical value, and under the heading of *Dietary for the Sick* a number of useful recipes are given. Parts I and II are followed by a number of blank pages, ostensibly inserted for the purpose of making notes on new remedies or of one's personal experience in the use of the remedies therein recorded.



In Volume II, no attempt is made toward a classification of drugs, but instead they are arranged in alphabetical order. The work is quite complete and up to date, the newer remedies being given place and careful consideration.

Speaking of the *oleates* the author, whose writings did so much toward popularizing the remedies, is frank enough to acknowledge that lanolin has replaced oleic acid as a combining agent when absorption is the effect desired.

In the volume are 987 pages of printed matter, the type is good, and a number of formulæ, including those for hypodermatic use, add greatly to the value of the work. H. W. B.

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## State News and Medical Items.

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[Communications from Physicians of Louisiana are solicited for this Department. News of personal interest is especially desired.]

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### CHARITY HOSPITAL.

#### MONTHLY MEETING OF THE BOARD OF ADMINISTRATORS.

The regular monthly meeting of the Board of Administrators of the Charity Hospital was held last night. There were present: Dr. Bickham, in the chair, and Messrs. J. H. Keller, Hugh McManus, George Seeman, and Drs. F. W. Sentell and W. H. Wiendahl.

The presiding officer made formal announcement of the death of Administrator Devereux, and resolutions of regret out of respect to his memory were presented and adopted:

The Board of Administrators of the Charity Hospital received with sincere regret the intelligence of the sudden demise, on yesterday, at Helinetta, N. J., of Mr. John G. Devereux, one of their members.

His association with us in the management of the institution throughout the administration of his Excellency Gov. Nicholls marked him as an invaluable auxiliary in our good work. His clear judgment, long experience as a financier, his scrupulous exactness in all essential requirements of this important trust, rendered him of material aid in its successful management; al

ways at its service, he never tired in devotion to its interests, ever proving himself an enlightened and conscientious coadjutor in the responsible position of administration; therefore, be it

*Resolved.* That the death of John G. Devereux terminates an invaluable service to this institution, a service unstintingly bestowed with marked ability, and which rendered him a valuable public servant in behalf of the State's great charity.

*Resolved.* That this preamble and these resolutions be inscribed upon the minutes of the board, and a duly attested copy, under seal, be transmitted to his family.

*Resolved.* That in the estimation of his worth and of its appreciation by the board, its membership will attend his obsequies in a body.

The report of the clerk for the month showed that there were 540 patients in the institution on September 1; 641 were admitted during the month, 78 died, 542 were discharged, and there were in the hospital on October 1, 561. In the clerk's financial report it was shown that \$605.20 had been received and turned over to Sister Agnes.

The board then proceeded to the election of its visiting staff, the following gentlemen being selected:

Visiting Surgeons—Samuel Logan, Ernest Lewis, F. W. Parham, J. F. Schmittle, E. D. Martin, H. J. Scherck, E. Souchon, Paul Michinard, R. Matas, W. E. Parker, R. U. Borde, Luther Sexton.

Visiting Physicians—J. B. Elliott, L. F. Reynaud, P. E. Archinard, J. Lauraus, J. T. De Grange, J. H. Bemiss, Joseph Jones, H. Bayon, H. S. Cocram, J. Hope Lamb, F. H. Brickell and J. M. Elliot.

Visiting Oculists—E. W. Jones, Wm. C. Ayres.

Visiting Aurists, Rhinologists and Laryngologists—E. W. Jones and W. C. Ayres.

Visiting Dentist—Dr. A. G. Friedrichs.

With reference to the alleged ill treatment of patients by the ambulance corps, the following letter from Dr. J. D. Bloom, assistant house surgeon, was read:

*To Dr. J. C. Bickham, Vice President Board of Administrators:*

MY DEAR DOCTOR—Concerning the inquiry requested by you, regarding certain cases cited in complaint of the conduct of the ambulance corps, I have the statements of those gentlemen who served on the occasion referred to, to the fact that at no time were they guilty of intentional wrong doing; that they acted to the best of their ability and conscientiously. At no time did they purposely offend or knowingly evidence disre-

spect for the scenes necessitating their presence. These gentlemen claim that their actions have been misinterpreted and feel themselves unjustly accused. With a just appreciation of the tender feelings of sympathy on the part of relatives elicited by the shock of emergency cases requiring the aid of the ambulance corps, and in fair acknowledgment of the active and heroic efforts oftentimes necessitated by students in attendance, in their efforts to succor—and admitting the ambulance service—a public charity open to public complaint at all times; I feel satisfied in the instances of which this report pertains in recommending the exoneration of the gentlemen to whom these charges refer. With much respect, yours very truly,

J. D. BLOOM, *Assistant Surgeon*.

NEW ORLEANS, October 5, 1891.

The board decided to attend the funeral of the deceased administrator, Mr. Devereux, in a body.

It was their intention to adjourn the meeting out of respect to his memory, but owing to the necessity of appointing a visiting staff for the next six months, this was denied them.

BATON ROUGE, Oct. 22.—A commission has been issued to Leon Joubert as a member of the Charity Hospital Board of New Orleans, vice John G. Devereux, deceased.—*Times-Democrat*.

DR. SOUCHON has returned to New Orleans. He spent his time examining the medical colleges of eastern cities.

DR. A. W. DE ROALDES has returned to the city after a three months' trip.

DRS. F. FORMENTO and L. F. SALOMON left the city to attend the American Public Health Association convention, which will be held at Kansas City, Mo., October 20 to 24 inclusive.

MARRIED.—MAGRUDER-FAVRE.—At Pearlinton, Miss., Wednesday, October 14, 1891, by Rev. T. W. Adams, Dr. M. J. Magruder of New Orleans and Miss E. A. Favre. No cards.

ARCHINARD-JOUBERT.—At the St. Louis Cathedral, New Orleans, on Tuesday, October 20, 1891, Dr. P. E. Archinard to Mrs. Joubert, both of New Orleans.

KILPATRICK-PIERSON.—In Natchitoches, October 15, 1891, Dr. Ralph Kilpatrick to Miss Alice Pierson.



DR. L. T. POSTELL, of Plaquemine, visited New Orleans last month.

Dr. W. G. Young, formerly of Rayne, has located in Centreville, La.

Dr. A. Maguire, of Jeannerette, was in the city a few days. The doctor was accompanied by his wife.

Dr. Wm. Martin U. S. N., has gone to Washington, D. C.

Dr. G. M. Guiteras, M. H. S., was in New Orleans last month on his way to Mobile, Pensacola and Mullet Key on special duty.

MISSISSIPPI.—Dr. E. A. Guilbert, of Jackson, died recently, and Dr. A. Johnson, of Purvis, died September 12.

NEW MEDICAL COLLEGE.—The bequest of \$100,000, left by Mrs. Ida Richardson to the Tulane Medical College, is to be applied by the trustees to the erection of buildings specially adapted to the purpose. The site which has been chosen is the old Woods' Cotton Press on Canal street, between Robertson and Villere. Plans are now being elaborated by Mr. Thos. Sully, the architect, and will be presented to the board as soon as completed. Dr. Souchon has visited the medical colleges of Baltimore, Philadelphia, Boston and New York. He was very cordially received everywhere and afforded every facility for study of their system and observation of their defects and advantages. Dr. Souchon has made the subject a matter of no little study, and by elimination of the faults and defects and incorporation of the perfections and advantages into the proposed system and building of the college has arrived at a plan which will make the institution a model of correct principles. The present school has been found too small. Advanced schools of medicine require large and extensive laboratories for chemical, microscopical, pathological and bacteriological study.

The amount of iodoform used in the Paris Hospital is something extraordinary, and seems to be "progressing favorably." The authorities contracted for a supply of 48,000 kilograms (about twenty-four tons) at the beginning of the year, but by last month the supply had run out, and the surgeons, like the daughters of the horseleech, were asking for more.

MEDICAL PRACTICE IN CONNECTICUT.—The following reply was sent to a doctor inquiring of a State official if he will be allowed to practise in Connecticut by registering his name and the college from which he was graduated:

“SIR—Anybody can practise medicine in Connecticut. You do not need to register; you do not need a medical diploma; you do not need to know the difference between opium and peppermint; you do not, indeed, need to know anything. You can simply come and live here and begin to practise. The laws of Connecticut will sustain you in collecting your fees for professional services, if you render any which you choose to call such. But if you undertake to carry me or my trunk to the depot for pay, you must get a license. If you peddle matches or peanuts, you must get a license. If you collect the swill from your neighbors to feed your pigs, you must get a license. If you want to empty your cesspool, you must get a license. But you can practise medicine in Connecticut *without a license*.”—*Hartford Post—Times and Register*.

RINGWORM IN DEMAND.—The following advertisement appeared the other day in a British paper: “Lady, having the care of two little boys with ringworm, wishes to meet with one or two others to share their educational advantages.”—*Med. Record*.

FROM AN AMUSING PAPER on “Our Predecessors, the Barber Surgeons,” read by Dr. Embleton before the Newcastle Society of Antiquaries, we learn that the barbers were fined for trimming their customers on the Sabbath day, and fines were also imposed when members used “ill words” to each other. For “giving” members the “lie” fines respectively of from three to six pence had been made. Were these excellent rules in force now-a-days, and if the proceeds were put into a medical poor-box, instituted *ad hoc*, we should have the nucleus of a very useful charity to assist those left destitute by our less fortunate fellows. A rough calculation, based on the number of infractions committed during the last few weeks, shows that several “most potent, grave, and reverend seigniors” would be mulcted in very substantial sums, and one can only regret that no machinery exists for levying this tribute.—*Medical Record—The Hospital Gazette*,

## ORGANIZATION OF THE SCHOOL OF MEDICINE OF THE UNIVERSITY OF TEXAS.

At a meeting of the regents of this university, held in June, at Austin, steps were taken to put the medical branch into operation next October. It was determined to arrange for eight chairs, with salaries affixed, ranging from \$3000 to \$2000 each. Dr. H. A. West, of Galveston, was elected to fill the chair of practice of medicine, and Dr. J. F. T. Paine, of Galveston, the chair of obstetrics and gynecology. The board determined also to have a three years' graded course, a session of seven months, and require an entrance examination. The medical branch of the university is located at Galveston. The State has about completed a building for the school on the block adjoining the Sealy Hospital, the gift to the State of Mrs. John Sealy. An election to fill the vacant chairs will take place in Galveston the latter part of August next.—*Medical Record*.

## THE LATE DR. FORDYCE BARKER.

At a meeting of the medical board of Bellevue Hospital held on June 1, 1891, the following resolutions were adopted:

*Resolved*, That it is with the deepest sentiments of regret that this board has learned of the death of Fordyce Baker, M. D., LL. D., who has been identified for so many years with the medical staff of this hospital as one of its most distinguished and deservedly esteemed members, that his removal at this time is felt by his colleagues as a special loss to this institution;

*Resolved*, That in Dr. Barker his colleagues have always recognized a man of exceptional endowments, both of mind and of education, which made him the ornament and pride of medicine, which caused him to be an example in these respects to his fellows;

*Resolved*, That the thirty-five years spent in ministering to the sick in this hospital with the faithfulness to that duty which characterized Dr. Barker is of itself a testimony to the worth of the life which has now closed. But, in addition to this, Dr. Barker used the opportunities of his connection with this hospital to teach others by his experience, by his wide knowledge, by his exceptional skill, and by his great literary gifts, to an extent which has been widely appreciated by the whole medical profession in America and abroad.

[Signed]

GEORGE WOOLSEY, M. D.,  
*Secretary of the Medical Board.*



MORTUARY REPORT OF NEW ORLEANS.  
FOR SEPTEMBER, 1891.

CAUSE.	White .....	Colored .....	Male .....	Female .....	Adults .....	Children .....	Total .....
Fever, Yellow .....							
“ Malarial (unclassified)....	6	9	10	5	5	10	15
“ Intermittent .....							
“ Remittent .....	2	3	3	2	4	1	5
“ Congestive .....	7	3	6	4	9	1	10
“ Typho-Malarial....	6	4	6	4	6	4	10
“ Typhoid or Enteric.....	8	2	4	6	9	1	10
“ Puerperal .....	1	1		2	2		2
Scarlatina .....							
Small-pox .....							
Measles .....							
Diphtheria .....	2	1		3	1	2	3
Whooping Cough .....							
Meningitis .....	3	2	4	1	3	2	5
Pneumonia .....	7	7	9	5	7	7	14
Bronchitis .....	7	2	4	5		9	9
Consumption .....	33	34	30	37	65	2	67
Cancer .....	4	1	2	3	5		5
Congestion of Brain.....	10		6	4	6	4	10
Bright's Disease (Nephritis) .....	13	4	8	9	15	2	17
Diarrhœa (Enteritis) .....	13	5	14	4	13	5	18
Cholera Infantum .....	2	3	3	2		5	5
Dysentery .....	9	1	11	1	12		12
Debility, General .....	4	1	2	3	5		5
“ Senile .....	11	8	5	14	19		10
“ Infantile .....	5	4	6	3		9	9
All other causes .....	136	76	124	88	137	75	212
TOTAL .....	289	173	257	205	323	139	462

Still-born Children—White, 24; colored, 25; total, 49.

Population of City—White, 184,500; colored, 69,500; total, 254,000.

Death Rate per 1000 per annum for City—White, 18.80; colored, 27.87 total, 21.83.

F. W. PARHAM, M. D.,  
Chief Sanitary Inspector.

## METEOROLOGICAL SUMMARY—AUGUST.

STATION—NEW ORLEANS.

Date.....	TEMPERATURE.			Precipn. in hundredths ..	SUMMARY.
	Mean	Max.	Min.		
1	81	90	72	.22	Mean barometer, 30.078.
2	80	88	73	.01	Highest barometer, 30.264, 17th.
3	80	87	73	.02	Lowest barometer, 29.924, 20th.
4	73	80	66	.03	Mean temperature, 77.9.
5	72	81	63	0	Highest temp., 90, 1st; lowest, 63, 5th.
6	72	82	63	0	Greatest daily range of temperature, 19, 9th.
7	75	83	67	0	Least daily range of temperature, 7, 10th.
8	77	85	69	0	MEAN TEMPERATURE FOR THIS MONTH IN—
9	78	88	69	0	1871.....82.8 1876.....81.9 1881.....82.8 1886.....81.4
10	76	80	73	.62	1872.....82.5 1877.....82.8 1882.....80.5 1887.....81.0
11	74	78	69	.09	1873.....81.0 1878.....83.6 1883.....83.3 1888.....78.2
12	71	76	66	.03	1874.....83.8 1879.....80.9 1884.....82.3 1889.....80.6
13	78	86	69	0	1875.....79.1 1880.....81.1 1885.....80.4 1890.....80.6
14	80	87	73	0	1891.....81.2
15	81	89	73	0	Total deficiency in temp'ture during month, 10.
16	81	88	74	0	Total deficiency in temp'ture since Jan. 1, 104.
17	80	87	73	0	Prevailing direction of wind, N. E.
18	80	87	72	0	Total movement of wind, 5673 miles.
19	80	87	72	0	Extreme velocity of wind, direction, and date,
20	78	85	70	.44	48 miles, from N. E., 20th.
21	78	87	68	1.85	Total precipitation, 3.43 inches.
22	78	84	73	.09	Number of days on which .01 inch or more of
23	80	88	71	.01	precipitation fell, 12.
24	80	88	72	T	TOTAL PRECIPITATION (IN INCHES AND HUNDREDTHS)
25	78	83	72	0	FOR THIS MONTH IN—
26	78	84	72	0	1871.....7.21 1876.....4.44 1881.....4.21 1886.....2.40
27	79	85	73	T	1872.....3.75 1877.....2.54 1882.....9.47 1887.....7.42
28	79	86	71	0	1873.....8.30 1878.....5.31 1883.....4.12 1888.....22.74
29	80	87	74	.02	1874.....4.82 1879.....10.44 1884.....0.87 1889.....5.59
30	80	87	74	0	1875.....5.61 1880.....4.60 1885.....4.25 1890.....3.62
					1891.....1.69
					Total deficiency in precip'n during month, 1.50.
					Total deficiency in precip'n since Jan. 1, 21.40.
					Number of clear days, 10; partly cloudy days,
					17; cloudy days, 3.
					Dates of Frost, .....
					Mean maximum temperature, 85.1.
					Mean minimum temperature, 70.7.

NOTE.—Barometer reduced to sea level. The T indicates trace of precipitation.

G. E. HUNT, *Local Forecast Official.*

## SYNOPSIS OF SUMMARY FROM SHREVEPORT. LA.

Mean barometer, 30.066.

Highest barometer, 30.249, 18th.

Lowest barometer, 29.913, 27th.

Mean temperature, 75.6.

Highest temperature, 91, 2d; lowest temperature, 54, 5th.

Greatest daily range of temperature, 28, 6th.

Least daily range of temperature, 8, 10th.

Prevailing direction of wind, S. E.

Total movement of wind, — miles.

Extreme velocity of wind, direction, and date, 26, S. E., 21st.

Total precipitation, 4.35 inches.

Number of days on which .or inch or more of precipitation fell, 5.

Total deficiency in precipitation during month, .22.

Total deficiency in precipitation since January 1, 4.42.

Dates of frost, —.

Mean maximum temperature, 91.

Mean Min., 54.

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Mr. FELLOWS, 48 Vesey St., New York.

New Series.

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December, 1891.

*Panlum sepultæ distat inertie  
Celata virtus.*—HORACE.

# New Orleans Medical and Surgical Journal.

Augustus McShane, M. D.,

Editor and Publisher.

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# NEW ORLEANS MEDICAL AND SURGICAL JOURNAL.

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VOL. XX.

DECEMBER, 1891.

No. 6.

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## Original Articles.

[No paper published or to be published in any other medical journal will be accepted for this department. All papers must be in the hands of the Editors on the first day of the month preceding that in which they are expected to appear. A complimentary edition of twenty-five reprints of his article will be furnished each contributor should he so desire. Any number of reprints may be had at reasonable rates if a written order for the same accompany the paper.]

### LYSÆMIA, OR MALARIAL HÆMATURIA. ✓

By E. H. MARTIN, M. D., GREEN GROVE, MISS.

An article under this heading in the September number of the JOURNAL by Dr. Bruce McVey, and another in the October number by Dr. Geo. W. Douglas, have interested me much: and I am influenced to add my feeble light on this dark subject by the belief that I really have a light to add, that it is apparently much needed and because I firmly believe that hundreds of patients with this disease are annually hurried to the grave by their physicians. This broad statement will come with better grace when I explain that I have in times past done my own share of the hurrying; indeed in those days I never let a case of "hematuria" live more than three or four days and have wound them up in much less time; and after that came a distrust of the teachings of the text-books and the profession at large upon this subject and a wild grasping at any sort of treatment that would give the patient half a chance.

And then I read an article in another journal by Dr. R. S. Williams, of Mount Meigs, Ala., in which he advocated an infallible cure—a plan of treatment so simple and so directly at variance with orthodox teaching on the subject that it required the courage born of desperation to apply it and trust it in the first case.

I found this treatment as infallible as Dr. Williams had promised; and now, after a series of cases brought speedily from conditions of hopelessness, at times with suppression of urine and grave uremic symptoms, to rapid and complete convalescence, it is as rare for me to feel any anxiety concerning even the most severe cases as it was for me to formerly have hope.

Some of my professional neighbors have tried Dr. Williams' treatment, and no one who has tried it has been disappointed.

And now that I have struck the right path, I often wonder why every one does not see it all at a glance, and I am amazed that I myself should have so long gone wrong. So much depends upon the point of view.

However, I find it very difficult to get some physicians to change their treatment, even when they admit a mortality of from 50 to 80 per cent.; a few because they would rather be orthodox than right; more, because the treatment is so simple that they are afraid to trust it when in the presence of the frightful disease. And, lest some who read this may be deterred from giving it a trial for the latter reason, as Naaman of old refused to merely dip seven times in the river Jordan, for which we can scarcely blame him; lest the treatment appear too simple to be useful I will give what is in my humble opinion the *modus operandi* of the cure.

Malarial hematuria, as we call it, occurs only in persons who are suffering from chronic malarial toxæmia. They may or may not have had frequent attacks of malarial disease, but they have always been exposed to the action of the poison for some length of time.

The blood of such a patient has become deteriorated, and a tendency to dissolution and disintegration of the red corpuscles exists.

Second, the long continued state of malnutrition has so weakened the walls of the capillaries that they are easily ruptured outright, the slightest trauma producing a bruise, or else allow a transudation of serum, as is shown by the œdema and anasarca often seen in such patients. Now add, as a third factor, a local increase of blood pressure in any part or organ

and we have an outpouring of blood coloring matter and broken down corpuscles through the ruptured capillaries.

The hemoglobin set free rapidly stains the sclera and skin an intense yellow, a jaundice generally without bile. The toxic agents set free by this process or retained by the disordered secretions, soon cause an uncontrollable vomiting and incessant nausea, at times delirium, always a relatively slow pulse until just before the end, a generally slight rise of temperature after the sweating stage of the final malarial attack; finally, after the kidneys are choked up by disintegrated corpuscles, suppression of urine takes place, and, if not speedily relieved, is followed by coma and death. All this may occur in less than twenty-four hours from the beginning of the attack, or it may take days.

Now it is evident that the first two essential conditions, those of the blood and capillaries, arise from malarial toxæmia: the third factor, the localized increase of blood pressure, is generally from the congestion of the internal organs incident to a chill and, I believe, almost always directed to the kidneys by the increased work these organs are performing in eliminating the quinia which has been given to abort that same chill.

I have never seen a case in which the patient had not been more or less cinchonized at the time of the attack; and judging from the bad effect that this drug has when administered after the disease is established it is but natural to suppose that in most cases it is more or less an exciting cause of the disease. Not always, for Dr. McVey asserts that he has seen cases who had not taken quinine for a year previous, and we are bound to believe that he is correct or at least that he had been so informed by the patients. And there may be much of coincidence in the results of my observation, for I am afraid that there is not a white person in this county who has not taken quinine within the past three months.

But, leaving out the quinine factor, the three essentials before mentioned are sufficient to explain the occurrence of the disease; and without the theory of a special hematuric germ as advanced by Dr. McVey. We speak of "malarial hematuria" as a disease, but, as I have tried to show, it is not



a disease *per se*, but a morbid condition resulting from a specific disease; a condition for which I have suggested the name "Lysæmia," in a recent article published in another journal,\* in lieu of the clumsy nomenclature now in vogue.

And as this morbid condition is far more serious than the causative disease, it becomes evident that the treatment should be directed first to the correction of the condition, for from the disease malaria there is but little more to fear.

The aims of treatment in the order of their importance are:

1. To clear up the urine.
2. To evacuate the bowels and keep them acting that they may aid in freeing the system from the toxic agents set free by the explosion, and better the state of the system for absorption of remedies and nourishment.
3. To repair the damage done to blood and blood vessels.
4. To administer any anti-malarial remedy which will not interfere with carrying out the other indications.

I place the clearing of the urine first in order of importance, because death almost always results from suppression of urine, and the suppression is due to the hemorrhage into the stroma of the kidney. The Malpighian tufts and uriniferous tubules must be kept free from clots with lumen clear; and if this is done the patient is not in imminent danger even if malarial paroxysms occur, which fortunately is not often the case.

The propriety and place in order of importance of the second and third indications will be admitted by all; and the fourth indication I place last for the reasons just mentioned, because the actual history of these cases gives few examples of recurrences of the malarial attack.

Just why this is the case I do not know, but the fact stands on record in nine cases out of ten. And if, with Dr. McVey, I may be permitted to indulge in a little private theorizing I will say that there may be certain chemical compounds formed or freed by the dissolution of the blood which are deleterious to the malarial germ, just as in alcoholic fermentation the process is retarded and stopped by the formation of the alcohol. This, of course, is only a speculative suggestion, but the fact remains that a patient with what we call "malarial

---

\**Atlanta Medical and Surgical Journal*, February, 1891.

hematuria" has *malaria* to fear the least of all the evils of his condition.

And now as to the means of fulfilling these four indications.

1. The one remedy *par excellence* for clearing the urine is turpentine. I usually give to an adult ten drops or a No. 1 capsule full every four hours, and have never failed to clear up the urine in from twelve to forty-eight hours. Improvement generally begins as soon as the odor of violets is noticeable.

The turpentine, in my opinion, acts not directly as a hemostatic, but as a reparative to the capillaries and as a diuretic.

I object to ergot or gallic acid for the reasons that, first they can have but very little if any effect; second, if they have, it is bound to be a bad effect, as they have no diuretic action. The ergot might increase the pressure in the capillaries, and the gallic acid give a tendency to clot formation, both of which we wish to avoid. As for digitalis, I do not think it is ever needed: the circulation is always oppressed and relatively slow, in some cases as low as sixty pulsations per minute—this from uremia; and if the digitalis has any effect toward contracting the capillaries that would certainly increase the blood pressure in them and enhance the danger; and digitalis can not have its usual diuretic action, for the kidneys are already engorged with blood.

Turpentine alone, given persistently as I have mentioned, will do all that one can wish toward carrying out the first indication.

2. The second indication may be accomplished by means of any purgative at hand. Calomel has no specific action; I give it in moderate doses in the beginning of the attack where vomiting is most severe, but prefer Epsom salts, and as routine treatment prescribe a tablespoonful of the latter every four hours until six or more actions have been produced and then *pro re nata*.

3. The third indication is met with nourishment and iron, preferably in the form of the tincture of the chloride. In a vitiated state of the stomach I do not believe that any other preparation of iron compares in utility with the old fashioned tincture. I

generally give a little nourishment, followed by from four to six drops of the tincture, well diluted, every four hours.

Suitable nourishment is generally difficult to obtain, for these cases occur mostly in the country away from markets and prepared foods. The most useful article in the largest number of cases in my hands has been buttermilk; it is always at hand in the country and generally more relished by the patient than anything else obtainable.

If a point is made with the patient and nurses that the iron is very necessary but will do harm if given on an empty stomach, there will be no trouble about the patient being nourished.

4. The fourth or anti-malarial indication I prefer to meet with arsenic—because it does no harm, because in the form of Fowler's Solution, it is palatable and readily retained: and further, because there is no hurry and we can well afford to await its slow but certain effect. Why not use quinine instead? I do not give it because quinine has killed every hematuric patient I ever treated with it. I have known many patients to recover from this trouble who had been treated with quinine, but the weeks of illness, the many relapses and the months of convalescence show too clearly that the recovery took place, not as a result of treatment, but in spite of it. The quinine must be eliminated, the kidneys have to do the work and they are not in condition to stand the additional strain. The urine becomes more scanty, more viscid and more tarry; suppression and death rapidly supervene. If the patient has the constitution to withstand the diseased condition and the quinine, too, he recovers, though very slowly.

Now for the sake of comparison, which is often as useful as odious, let us glance at a typical case of the severest kind treated by the usual method and a similar case treated by what I choose to call the rational method.

You are called to see a patient, probably a young man of thirty; he gives a history of chills and possibly has been taking much quinine. Before sending for you he has had a severe chill and is suffering much from nausea and vomiting, temperature 103 deg., pulse 90. You observe a slight degree of jaun-



dice and the pot contains half pint or so of bloody or blackish urine. You prescribe calomel, also quinine and other drugs to meet the symptoms and leave. You return in the evening and find your patient very yellow, with uncontrollable vomiting, bowels may or may not have acted, urine is scanty and very thick, the color of coffee grounds, temperature 101 deg., pulse 75. Treatment continued; the dose of the quinine is doubled. The next morning you find the symptoms intensified, the urine is suppressed, temperature 99 deg., pulse 65. Night comes and with it delirium, temperature 99 deg., pulse 70. Coma supervenes. You wait and watch. Before daylight you notice that your patient's pulse is 90; an hour later it is 120; in another hour it is 160; the respirations are more and more slow and labored; soon the pulse is so fast and feeble that it seems a mere flutter and you can not count it. The patient gasps for breath now but once or twice a minute; now he gives a last gasp; the heart still flutters for a minute or more and then all is still. Your work is done.

This is not exactly an imaginary case: I have had the unpleasant experience several times.

And now for a similar case treated without quinine. We will suppose it even worse and say that you are not called in until suppression has taken place and delirium ensued. You find a man more deeply yellow than a lemon, tossing in the bed or gazing into vacancy while plucking the cover. He rouses only to vomit and call for more water. You are shown the last urine that has passed; it looks like tar inspected through a red glass. His bowels are not acting; temperature 99, pulse 70. Your first instruction is *that no more quinine be given*. Next you prepare your remedies in suitable form for administration. Then you write out a schedule something like this.

1 P. M.—Turpentine.

2 P. M.—Nourishment; iron and arsenic.

3 P. M.—Epsom salts (or other purgative).

4 P. M.—Arsenic alone (2 drops).

And so on for each succeeding four hours of the twenty-four, then the schedule to be repeated.

If the vomiting is exceptionally troublesome you omit the nourishment, arsenic and iron for the first twenty-four hours.

You write across the list in large letters, and add verbal emphasis, that any dose if vomited is to be repeated at once. You give instructions that the nausea and vomiting are to be controlled by wetting the face and neck and rapid fanning after each dose and oftener if needed. You will have to explain to the friends that only one drug at your command will in the least degree control the vomiting, and that is morphia hypodermically, and that you do not wish to give morphia as it will have a bad effect on the secretions.

You return the next day to find but little change. The nausea is probably less, since the bowels have acted several times; there has been a little urine passed about as bad to behold as before, otherwise no change; temperature 99 deg., pulse 70 deg. You return on the next day to find your patient resting better, and rational; bowels open and salts discontinued; urine free and fluid but still bloody; temperature 99 deg., pulse 80 deg. The next day patient is better, but very weak; retains his nourishment and medicine; urine a transparent red; temperature 99 deg., pulse 90.

On the following day the urine is clear and the turpentine is discontinued; salts to be given as needed: complexion is becoming more clear; a little solid food is allowed, but not relished; temperature 99 deg., pulse 85. The treatment now is only the iron and arsenic given in increased doses, and only after food is taken. The appetite mends apace, and in another week the patient is out of bed. Convalescence is speedy; iron and arsenic continued a month. This is also not an imaginary case. I have had to make use of suppositious cases because my cases have been or are to be reported elsewhere, but the above is typical of them all. Where you are called in sooner the recovery is correspondingly more rapid.

And now why was this disease not observed before the 50's? I believe that it did occur in those days; we hear of unaccountable cases of "yaller janders" following chills many years before that time, and quite recently I have known a physician to diagnosticate a case of this kind as "yellow jaundice;" another called a case yellow fever and created a sensation; every day there are being discovered new diseases which existed always though unobserved or undifferentiated.

Kidney disease must have been a very ancient complaint before the time of Bright. But "hematuria" was certainly not so frequent forty years ago as now. First, there were not so many people and these were hardy pioneers; second, there was not so much quinine used. For, while cases may occur without quinia, I firmly believe it precipitates the explosion in a large majority of instances. I know of subjects in whom I can produce a typical case at any time (after one or two chills) by giving twenty grains of quinine.

As to its not occurring in and around New Orleans where quinine is much used—it *does* occur there, as the records of Charity Hospital will show. That it should be less frequent in a city is to be expected, as suitable subjects are rarer. A person of means calls in his physician, and the poorer classes can go to the dispensaries after the first chill. It is more often the planter, the levee builder or the civil engineer, far from a physician, who try to doctor themselves and become fit subjects for this condition. The fact that quinine is much used in New Orleans goes to show that the people have treatment early and are not allowed to run on until ready for "lysæmia."

Why are most of these cases of the male sex? Because the women are less exposed and better cared for, hence are less liable to become fit subjects. And why is the negro race partially exempt? Because nature gives them more power against malaria; but there have been five cases of "hematuria" in negroes in this neighborhood in the past two years, so nature does not exempt that race entirely.

I must beg to differ from the two gentlemen who have lately written on this subject on one more point. That is as to the reported irregularity of the symptoms in different cases and different localities. True, each patient marks his own case with his own individuality and personal idiosyncrasies; and some have symptoms that others have not. One may have black sputum just because he happens to have a chronic passive hyperæmia of the lungs, due maybe to semilunar obstruction or other cause, and other patients will not have this symptom: just as one patient may have blackish effusion in a blister which others have not because they are not blistered.



But above all of these personal symptoms for which the disease and condition is not wholly responsible, there stand preëminent the three cardinal symptoms which, taken with the history, are pathognomonic:

1. Hemaglobinuria.
2. Nausea and vomiting.
3. Intense jaundice.

And a comparison of the apparently very different cases of Drs. McVey and Douglas will show these cardinal signs in each.

But while personal idiosyncrasy may impress each case, I can not believe that a change in locality could influence the natural history of the disease except as to frequency and possibly severity.

And now a word as to the nomenclature of this condition. The word hematuria is incorrect, for pure blood is not found in the urine. Hamaglobinuria is better, but is merely naming a symptom, not describing the pathological state. So with yellow chills, swamp yellow fever, black chills, etc.

Hemorrhagic malarial fever is a glaring misnomer. To begin with, there is generally but little fever, and this is nearly always septic rather than malarial; and true hemorrhage does not occur in this or any malarial fever unless from secondary causes. Finding all of the names in use open to objection I have suggested the name *lysæmia* (*lyōō*, to lose, and *αἷμα*, blood) as more nearly descriptive of the pathological condition, better expressing the fact that there has been a dissolution of the blood and a loosing of the integral parts of it as a cause of the objective symptoms. But I will not press the matter; it makes little difference what we call it; a disease by another name will kill as quickly.

Of my brethren of the profession I wish to make an earnest request. I am attempting to secure reports of a sufficient number of cases treated by different plans to warrant the drawing and comparing of percentages of successes by each treatment. It will take several hundred cases to arrive at anything like correct statistical conclusions. And I will greatly appreciate the kindness if you will send me reports of either *all* of your cases, or of *all occurring in a given period of time*. No

selected cases desired. If the results of this compilation are ever published, each physician will be credited with his own cases.

\* \* \*

Since sending in the above I have read the article of Dr. John W. Meek in the November number of the JOURNAL. It gratifies me to see that he has fathomed the question as to the usefulness of quinine in this condition. But I can not agree that "in the hands of some, quinine is the panacea—" for its most ardent advocates admit a high mortality rate due, they say, to the natural malignancy of the disease.

He abandoned quinine, and was more successful with hyposulphite of sodium. Hence, he very naturally (but to my mind, erroneously) concluded that hyposulphite of sodium has a specific action. If he will but consider that in these cases it is not the malarial toxæmia, but the condition of lysæmia, which we must first treat, he will no longer feel called on to explain "why quinine will cure nearly all other forms of malaria but this;" and "why hyposulphite of sodium will cure many cases of malarial hæmaturia, and be worthless in the ordinary manifestations of malaria" will no longer be a hidden mystery.

The hyposulphite simply acts as an excellent purgative, and nature, unmolested by quinine, does the rest. I can not but think that if he will add turpentine and leave off the morphia, his 25 per cent. of mortality will be reduced to almost nothing.

If space will permit, I will give some lay evidence on this subject. An old negro, recently from North Carolina, whose child I had been treating for intermittent fever, came into my office the other day to report that his child was no better. I accused him of not having given the quinine. He acknowledged this, saying that he was afraid to give it, as quinine made some of his children have Roanoke fever. I naturally asked what he meant by Roanoke fever. He replied that it was the North Carolina name for the disease from which his nephew had recently died. Now I had seen his nephew when in articulo mortis and knew that he died from lysæmia. The history given by this patient to the attending physician had been

as follows: He had been having chills and was told to take quinine; he took a large dose and in about an hour had a hard "shake," and his urine became bloody; he took more quinine and had another "shake," and again and again, each time producing a "shake."

I asked the old man if any of his children now with him were affected thus by quinine. He cited his grown daughter, who he claimed had had at least half a dozen attacks, every time in fact that she had ever taken quinine. He stated that she would take a dose of quinine, and in a few hours would have a hard chill and bloody urine. When asked how the doctors treated her for this he very frankly stated that the doctors had given it to her and he was afraid to call them back again: that he always took her in hand himself, filled her full of hot water and put her to bed to sweat, and that he kept giving her all the hot water she could drink until she got well. Now this old negro has evidently cured at least half a dozen cases or attacks of what he called malarial hematuria with hot water, and yet no one would place hot water on the list of anti-malarials, nor should the hyposulphite of soda be so placed.

The history of this family would seem to sustain the claim of Tomaselli for hereditary idiosyncrasy as a causative factor in producing this condition. It is the only instance I have seen, and I believe that the facts that the members of the same family breathe the same poison-laden atmosphere, drink the same water and labor under similar conditions, are more accountable than heredity for the apparent idiosyncrasy.

---

#### DYSTOCIA FROM BIFID UTERUS.

By ROBERT LAYTON, M. D., MONROE, LA.

Mrs. D. G., age 31, Jewess; general appearance good, but of very short stature, not exceeding five feet, and apparent distance from chin to pubis less in proportion than usual. Good health until marriage at nineteen years of age. Became pregnant soon after, and was delivered of a seven months' fœtus



after a twelve hours' labor, during the latter half of which she suffered from puerperal eclampsia, according to statement of her husband. Has not been pregnant since that time, twelve years since, and menses have been very irregular; from time to time they missed for several months, and she had been treated in several cities for this condition. She also suffered from occasional attacks of *petit mal* from the date of last confinement, the spells coming on at regular intervals. During a period of time, embracing last pregnancy, menses have been absent for about two years. Five months ago was called to see patient on account of a supposed abdominal tumor, pregnancy not being expected, as she had none of the usual symptoms, and menses were habitually irregular.

On examination, which was rendered very difficult on account of the thick deposit of adipose tissue in abdominal wall, found a four to four and a half months' pregnancy, but did not detect any fœtal heart, though "choc" and placental souffle were both *en presence*. Os uteri appeared normal on digital examination. The relative position of uterus and contents seemed a little abnormal, and, as I afterward remarked to Dr. Aby, the uterus appeared to me to resemble nothing so much as an old-fashioned wallet slung transversely across the lumbar vertebræ.

On account, however, of the extreme fleshiness of the woman, an accurate bi-manual mapping out of the uterus could not be made. Pregnancy advanced as usual, with few, if any, of the usual unpleasant symptoms, except obstinate constipation, until October 31, on the morning of which day pains set in, together with a slight vaginal discharge of blood of not sufficient quantity to be taken into account. Was called at 1 o'clock, and found the os dilated to the size of a silver dollar, with uterus presenting; os soft and dilatable, but head entirely above reach of index finger. At 4 P. M. I returned to the house and found that dilatation had been completed and diagnosed a left occipito-posterior position.

At 6 o'clock, the liquor amnii, of which there was an unusual quantity, escaped and the head engaged in the brim. Pains now became strong and frequent, but of a peculiar rhythm, and the fœtus was lying directed obliquely to the me-

dian line on the right side. The position of fœtus was rectified, and the nurse directed to retain it in median line, but after two or three pains it slipped completely over, and occupied a position exactly the reverse, on the opposite side.

The pains were of a rhythmical nature; first a pain and contraction of the right lateral half of the uterus would take place, then a short interval, during which the right half of uterus became flaccid, and then the left half contracted and relaxed in turn, with the usual interval of time for rest between.

Pains continued of this character, and notwithstanding all our efforts the fœtus would slip from right to left and *vice versa*, and always obliquely to median line, and though pains seemed sufficiently sustained, no descent of the head could be observed.

This condition of affairs continued during the whole of the night of the 31st without the real cause of their phenomena being suspected. But I concluded to apply forceps as soon as morning came, though I could see no reason for the delay in delivery other than above mentioned, as the pelvis was ample and head not of unusual size. At 7 o'clock in the morning I called Dr. Aby, who arrived at 8.

After an examination and short discussion the Doctor coincided in the opinion that forceps had better be applied, though he could see no other reason than myself why labor should not be completed naturally.

Patient was put under chloroform at 8 o'clock and forceps applied without difficulty by Dr. Aby. Traction was then made with each succeeding pain, but all to no effect, the head descending slightly only to recede within the pelvis as soon as traction was suspended. Finally, after many efforts and much force, the forceps slipped, leaving things in their original condition. Another pair was applied, and with a like result, except that in slipping the bones of the cranium were fractured and the vaginal wall slightly torn. Again another pair was applied without difficulty and considerable force applied without reference to pains. This had the effect of bringing the head well down against the perineum, but when it had reached that point, the head being now broken and the bones friable, the

forceps again unfortunately slipped and the head receded to its original position within the pelvis.

This condition of affairs was decidedly provoking and puzzling, and after a short consultation it was decided to make a craniotomy. The perforator was easily applied, and an attempt made to use the forceps to drag down the head, but the cranial bones were so very friable and brittle that only the portion within the grasp of the jaws came away each time it was attempted.

Again and again were the forceps applied with a like result until we gave up the job in despair. The situation was now decidedly interesting; the patient had been under chloroform for over two hours, pulse was weak, respiration shallow and yet the actual condition not changed.

It was evident that something had to be done, and that rapidly, to effect delivery. We decided to make podalic version, and with this purpose in view Dr. Aby essayed for some time to discover and bring down the feet, but to no avail. Each in turn made the same effort, until after a considerable lapse of time Dr. Aby reached a knee and withdrew it: the rest was then easy and the body was delivered. The head, however, required the exercise of all our muscular strength, until finally after a smart struggle it was in turn delivered, to the great bodily and mental relief of two perspiring and exhausted disciples of Æsculapius. Introducing the hand immediately to discover the cause of the difficulty, as nothing about the child suggested the least thought of deformity, and remove the placenta, my hand passed through a sufficiently capacious brim and inferior tract into an *empty uterus*.

Here was a puzzle. The placenta was not yet expelled and was not in the vagina.

Upon withdrawing the hand to search the cord it came into contact, just within what had been the external os, with a thin, rigid septum extending from superior to inferior margin of what had been the internal os and dividing it into two nearly equal parts.

The cord was now discovered leading up to the operator's left of this septum, and the placenta easily found lying on the



floor of the left—operator's—horn of a now evidently bifid uterus and easily removed.

The bodies of the two uteri were now explored as carefully as circumstances would admit, and it was found that their junction was about what ought to be the internal os—in normal non-pregnant uteri—but that above that portion their bodies were distinct.

The one body, the smaller, lying in the left vaginal region and extending above to a line two inches above umbilicus at right angle to axis of body, while the other, in which the fœtus was evidently developed, and occupied a corresponding situation on the right, but was larger and extended to seemingly, the inferior surface of liver.



The uteri were now emptied of clots, and injections of hot water and vinegar—as delivery was followed by some hemorrhage, made into both with a double current syringe. Things now began to assume a decidedly bluish hue. The patient had been under chloroform over three hours and there had been a second hemorrhage. Pulse weak and exceedingly rapid and respiration shallow.

Injections of brandy, ether, atropia and morphia were administered hypodermically, but to no purpose, as patient succumbed three hours after delivery, as we supposed from the combined effects of chloroform shock and hemorrhage.

A *post mortem* was earnestly solicited, but was refused by the husband.

This case is one that both Dr. Aby and myself thought worthy of record, as the recognition of the true state of affairs was only made after delivery, and we could by no means account for the tremendous difficulty encountered in delivery. Even after the bifid condition of the uterus had been ascertained, it was hard, and is still, to conceive what were the causes which led to the retrocession of the head after it had been brought well down against the perineum, and the extraordinary difficulty which was experienced in its extraction after version.

The obliquity of the long diameter of the fœtus in relation to the line of traction does not alone explain it, as the head and body of the child were not abnormally large, and the pelvis quite roomy. The resistance was simply tremendous, and we are of opinion that this cause alone could not have been operative. Consequently we are lead to believe that the real cause lay in the existence of a double os uteri, the dilatation of one of which was directly opposed to that of the other.

I add a diagram of the uterus and two horns as accurately as we can sketch.

#### A CASE OF OTITIS PARASITICA—OTORRHEA—DEAFNESS— ARTIFICIAL DRUM-MEMBRANE.\*

By JAMES L. MINOR, M. D., MEMPHIS, TENN.

I have selected this case of multiplicity of diseases, not on account of its novelty alone, but because in relating it several important points in ear disease are emphasized; and, too, the case presents some features of special interest. A synopsis of the case is as follows: *Disease of external ear from vegetable fungus (aspergillus)—cure; chronic inflammation of middle ear, with persistent discharge (otorrhea)—cure; deafness of eighteen years' duration, relieved by artificial drum-membrane.*

Mr.——— consulted me about his ears, January 13, 1888, and gave the following history: Aged 55 years. Never heard

\*Read before Tri-State Medical Association of Tennessee, Arkansas and Mississippi, 20th November, 1891.

well. In 1849 earaches, and following these discharge from each ear, which continued until 1870, when it yielded to treatment, but left deafness so great that only loudest tones of voice could be heard, and pencil and tablet had to be resorted to. This condition continued until 1880, when the hearing became worse and the discharge reappeared, and so remained until I saw him. I found absolute deafness in the right ear, the drum being retracted, thickened and scarred. In the left ear only the loudest sounds could be heard; the auditory canal was inflamed and covered with a membranous material of a blackish color; there was a perforation about the size of a pin head near the center of the drum, from which pus, from a suppurating middle ear, escaped. My treatment was confined to this ear. The ear was cleansed by syringing with a bichloride of mercury solution (1:5000), then dried with absorbent cotton, and tamponed with boric acid powder.

This procedure was repeated daily, at first, and then at longer intervals, over a period of about a month, at the end of which time all inflammatory symptoms subsided. The hole in the drum remained, however, and the hearing was as bad as ever; hence I decided to try an artificial drum. I first used the little rubber disc, so often tried, and so rarely beneficial, and got no help from it. I then extemporized an artificial drum, by taking a bit of absorbent cotton and moulding it into a thin disc the size of the drum-membrane. This was moistened with equal parts of glycerine and water, and applied to the drum of the ear. As soon as it was properly placed, there was an instant change in the facial expression of the patient, and he joyfully exclaimed that he could hear; that the noises from the street sounded again after a silence of eighteen years, and I was asked to speak, that the human voice might be heard naturally again. I did speak and found that he could hear and understand, when I spoke in an ordinary tone a few feet from him, but that elevation of voice was necessary when I was further removed.

This patient has been under observation for nearly four years. He is still, to all intents and purposes, absolutely deaf, except when an artificial drum is worn, but with it in place he hears well enough for all practical needs. The drum has to



be changed every month or so. Occasionally the middle ear becomes inflamed, and the drum has to be removed while treatment for that affection is practised.

The dark membranous material which came from the ear when treatment was begun, I examined microscopically, and found that it contained a certain form of vegetable mould (*aspergillus flavescens*), which sometimes gives rise to a very obstinate form of inflammation of the external auditory canal. In this instance it yielded to the treatment first instituted, and has not returned.

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#### ANGINA PECTORIS—ITS PATHOLOGY AND TREATMENT.\*

T. C. TOWNES, PH. D., M. D.

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The subject of our paper is one which has of late attracted as much attention almost as tuberculosis. Allow me to introduce my subject by citing a case which is now under observation.

Miss Clio E., æt. 11, suffered in 1884 from measles. Some time after that had an attack of malarial fever, when she noticed a palpitation of the heart accompanied by pain in the cardiac region and difficulty in breathing, and was forced to assume the erect posture in order to breathe. Since then there has been a frequent recurrence of attacks.

This patient presents valvular disease, insufficiency of the mitral and aortic valves, with the disturbance of compensation—symptoms of a definite character which do not depend upon a valvular defect.

These symptoms are what may be termed angina pectoris, or stenocardiac paroxysms.

In many cases of heart trouble the patients have no subjective difficulties, or they manifest themselves in the form of dyspnœa, or a sense of oppression, which occur after severe exertion or in connection with disturbance of compensation.

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\*Read before the Tri-State Medical Association, October 29, 1891.

Here enters the feature—pain in the symptomatology of heart disease, and it presents a definite character.

The classical picture of these paroxysms is that of one of the most dreadful of human experiences. Its characteristic feature is the sensation of impending death—he who never experienced such sensations can not form of them an approximate conception. The dread of death in full consciousness must be a most thrilling sensation. To this sense of destruction are added the pains in the cardiac region, rendering the position more tormenting and unbearable. There is a clawing and grasping pain and a feeling as though the heart were standing still and life ebbing away. But the pain is not confined to the cardiac region alone, but radiates thence to the thorax, even to the arm and the finger-tips. Both arms may be attacked, accompanied by a condition of paresis of one or both extremities. The phenomena are of varying degree and different duration.

The objective process is also varying and does not always accord with the patient's statements. The victim may be suddenly attacked on the street, he looks for a support, leans against some object and always finds that rest gives the greatest relief. The countenance is unchanged or becomes anxious. Respiration is calm in most cases, though in others may be irregular and deep. Pulse may be in one calm and even, in another arrhythmic and presents those peculiarities which are evidence of a definite heart lesion; the heart beat may sometimes be subjectively felt by the patient. The loss of consciousness may sometimes occur, and when it does, it is the result of several factors, as depressed heart action, pain and the feeling of impending death. Certain reflex symptoms may likewise show themselves, such as nausea, vomiting, pain in abdominal organs, etc.

Now in answer to the question which you may ask, under what conditions does this disease develop and what is the explanation? I will say there are three causal groups to be discussed. First, we have pseudo anginose difficulties, because the pain is not caused by any heart affection; second, those which may be diagnosed as sclerosis of the coronary arteries;

this is the severest and most ominous form; third, those arising from valvular defects.

Many investigations have at times proven that in the hearts of patients suffering from stenocardiac spasms, no modification was formed, but the angina pectoris depended upon vascular convulsions proceeding from the aorta to the vessels of the extremities, and many post mortem examinations show that the condition is based upon sclerosis, especially of the coronary arteries, and it is reasonable to conclude that these arteries may be the seat of this affection like other peripheral vessels.

An endarteric degeneration develops in them, and as a result, further modification of the vascular walls and myocardium. Anatomical investigations have shown that this modification or myocarditis has its origin in sclerotic changes of individual coronary arteries which are particularly end arteries. This condition of the arteries has been experimentally produced by Cohnheim in dogs and the result applies to man also.

In accordance with the stated anatomical condition of the heart, it is probable that the angina pectoris is caused by sclerosis of the coronary arteries. But this is not always the case, for on the other hand "anginous symptoms are more frequent in valvular defects, that is in distinct valvular defects, especially of the aorta." (Note case cited in the beginning of this paper.)

The symptoms of angina pectoris strongly recall neuralgia, and we must confess that we have not progressed much further in the recognition of the disease; that the seat of the pain is in the cardiac plexus, or whether this plexus is alone involved or other places are centers of the affection, we do not yet know. If the affection of the sympathetic is considered in connection with the sense of expiring, with the anxiety and oppression which the patients have, we must assume an affection in the bronchial plexus in order to explain the anæmia and radiating pains in the arms. Whether this radiation takes place in the central nervous system or follows in the peripheral courses, we certainly do not know; that it does take place, though, we conclude from analogous processes in other nerve regions.



The treatment of angina pectoris depends in the main upon the cause. One who smokes a great deal you will certainly forbid to smoke, otherwise all treatment will be baffled. And one suffering from stomach trouble must be freed from this stomach affection. In cases in which the stenocardiac attacks result from endocarditis, with symptoms of valvular disease of aorta or sclerosis or the coronary arteries, first of all regulate the diet and give alkaline waters and employ medicinally the nitrites—nitro-glycerine, nitrite of sodium and amyl.

The amyl-nitrite is given in the condition of angeio-spasm. It is very volatile and is easily administered by putting a few drops on a handkerchief or in the form of glass beads containing five drops, these being crushed in a handkerchief and inhaled. The effect generally shows itself in two minutes or more, the patient experiences a peculiar sensation, a feeling in the head of heat and dizziness.

The nitro-glycerine produces symptoms similar to the amyl, but being a crystalline solid the effects are not so fugacious. It is best administered in solution or in tablet form, increasing the dose, which is from 1-100 to 1-500 of a grain, to the point of toleration; then stop its ingestion and repeat, beginning with the original dose.

The iodide of potassium and arsenic from their general tonic effects, may also be given.

#### IN WHAT RESPECTS ARE THE THERAPEUTIC INDICATIONS IN ACUTE DIFFUSE PERITONITIS MODIFIED BY THE ETIOLOGICAL FACTORS?\*

By THOMAS H. MANLEY, M. D., Visiting Surgeon in Harlem Hospital, New York.

To this question one might at once give a definite and epitomized answer, that in diffuse peritonitis the same therapeutic indications exist, according to causative conditions, as in the general inflammation of any other serous membrane in the body.

Regardless of the causation, the objective treatment

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must be identical in all cases of diffuse peritonitis during its acute stages. This will be directed with a view of relieving pain, securing rest, sustaining the patient, moderating the violence of the disease, or aborting it in its early stages.

The fundamental principles which should guide us in the therapy of the malady under consideration, notwithstanding the extensive experimental work of the laboratory and studies of a biological and bacterial character, have undergone no material change in our time.

It was supposed that the antiseptic theory and the discovery that the great lymph sac of the abdomen might be invaded with impunity, would revolutionize the treatment of peritoneal inflammation. But it required only a brief period incontestibly to demonstrate that chemical solutions when introduced into serous cavities, by their irritating action were so frequently followed by direful results, that they seldom or never can be safely employed for flushing the peritonæum. The claim that exposure and manipulation of the peritonæum, is a harmless procedure, is another modern delusion; for we have no evidence to-day, of any description whatever, that the peritonæum is any less vulnerable to violence than it was in a past decade or century.

#### I.—GENERAL IDIOPATHIC PERITONITIS.

Independent of an infective inflammation arising from a diseased organ or structure and thence propagated to the entire serous membrane, we will meet with peritonitis, in association with those constitutional maladies, in which one or more fibro-serous membranes is the seat of inflammatory changes.

That general peritonitis may develop *de novo*, I believe is beyond question; arising from sudden atmospheric changes, exposure and depressed health.

Malaria, syphilis, tuberculosis, malignant and benign tumors; renal, hepatic and cardiac diseases, with many other maladies, in which the depuration of the blood is defective, the peritonæum is often the seat of a low, insidious form of inflammation, attended with a large serous effusion.

The causative factors, underlying all those varieties of in-

flammation in every instance, is irritation, the irritant being conveyed through the circulation to the seat of action. A clinical peculiarity marks the different varieties of peritoneal inflammation. They are all *painful* or *painless*. In some of these cases, however, in which the peritoneal inflammation is secondary, is pain generally of a less aggravated description. Indeed, not infrequently, congestion, effusion and absorption, may pass through these various stages without any serious inconvenience, except from the pressure of accumulated fluid, against adjacent viscera.

In all these cases of general peritonitis, arising in connection with certain constitutional maladies, treatment must be directed rather toward the several conditions than to local manifestations.

For that phase of the malady dependent on specific infection, the mercurials will be administered with a free hand; for the malarial, arsenic and quinine; for tubercular, such remedies as modify or arrest the course of that pathological process.

Certainly, when ensuing as a consequence of toxic elements in the blood, which have been derived from an infectious disease, the efforts of the medical attendant must be mainly directed toward neutralizing the poison in the circulation and stimulating the emunctories, to hasten its elimination.

## II.—APPARENT IDIOPATHIC PERITONITIS; NOT DEPENDENT PRIMARILY ON CONSTITUTIONAL IMPLICATION.

Of late years it has been maintained by many distinguished authorities, that it is a question whether acute, diffuse peritonitis ever develops, except as a secondary consequence of pathological changes in parts adjacent to the peritonæum; as infection from perforation of the intestine, or propagation of inflammatory changes in structures, over which a reflexion of the peritonæum may lie.

If this position were tenable, one would reason that the whole therapy of acute peritonitis must be revolutionized; for instead of treating the case on empirical lines, as is the practice which generally obtains, we should commence in every



instance by first endeavoring to ascertain the precise etiological factors in operation in each case.

If, for instance, if there were perforation of the intestine, gall or urinary bladder, rupture of an abscess, or extension of an ulcerative process, we would open through the abdominal walls, seek out the source of the original trouble, remove whatever effete or septic material may lie in the way, repair the lesion and close in the parts.

This is the only logical conclusion to which we can arrive in these premises; hence, our therapeutical resort should be rather mechanical and chemical than empirical or vital.

Acting on this assumption, of late years, so extensive and frequent are becoming sections into the peritonæum that a new specialty has arisen, known as "abdominal surgery." And, instead of the ancient cautious, conservative methods, which were characteristic of a past generation of practitioners in dealing with diffuse peritonitis, latterly the scalpel has been boldly taken in hand, the abdomen opened, its contents freely and leisurely manipulated, the peritoneal cavity drenched with chemical solutions employed to destroy infective agencies and prevent the further advance of inflammatory changes. Besides, a tube was left in the gaping wound to carry away the residue remaining of effete products.

Very often when the abdomen was opened, in conformity with this line of practice, no well defined local lesion could be discovered, but rather a yellow plastic, flocculent material, in places partly organized and adhesive, and again, more or less of it undergoing disintegration.

When the belly was opened under these circumstances, the consequences were usually mortal, few surviving twenty-four hours after the operation.

While the theory which has been advanced, that general acute peritoneal inflammation always arises from local morbid changes, is not wanting in pathological support, as revealed by post-mortem examination in the majority of cases, yet, when we have a correct knowledge of the wonderful and peculiar property of the peritonæum in walling off and confining suppurative accumulations, sealing up perforations, absorbing secretions, and often providing a vent for them through the ex-

cretory ducts, we can the better comprehend the processes of nature, called into active operation when the integrity of this serous membrane is threatened.

The present general reaction, both in America and Europe, against the employment of antiseptics, chemical solutions of every description, in the surgery of the serous cavities; the conceded imminent danger to life always attendant on incisions which entail exposure of the abdominal organs; the additional risk connected with pulmonary anæsthesia, in the presence of a high temperature and active inflammatory processes, have each and all served as warning, which none but the rash and reckless will ignore, and which, after all, in the treatment of general diffuse peritonitis, have left us about where we were when opium was regarded as our sheet-anchor.

Admitting, then, in part at least, that general, acute peritonitis is most frequently a secondary process; still, when measures are instituted which contemplate the exploration of the peritoneal cavity, and dealing directly with diseased foci or the primary lesions, such intervention is attended with so much danger to life and the prospects of recovery so much lessened, that our reliance must be rather on tentative than radical methods; on internal, epidermic and hypodermic medication; on sound hygiene and such measures as will sustain the strength, until the violence of the disease is spent.

### III.—TREATMENT OF PERITONITIS AS BASED ON CLEARLY DEFINED ETIOLOGICAL FACTORS.

Owing to the periodical activity of the female generative organs within the pelvis; to their abuse, their frequent pollution by infection through contaminated wounds along the genital tract; and to the demands of modern life in women, peritonitis, local and general, is a very common disease. But with them it usually pursues a subacute or chronic course, except in the puerperal variety, and is, comparatively, seldom fatal.

I never saw but one case of non-traumatic peritonitis, in the female, end fatally.

On the contrary, with the male, diffuse acute peritonitis is a comparatively rare disease. It runs a short acute course and is attended with a great mortality.

This notable contrast in the sexes; the clear and unmistakable etiological factors in the one, and the greater gravity in the other, have a distinct and important bearing on the question of treatment.

The pain of peritonitis, in women, not being so violent, is better borne; we may deal with her case in security, with milder measures. But with the male, our intervention must be prompt and energetic; for peritoneal pain, if not subdued, is quickly mortal with him.

Now, the physician, in the presence of a typical case of general acute peritonitis, devoid of complications, must not stop to concern himself about the original, etiological factors, but proceed at once rather to deal with *a condition*. This brings us to the question of treatment, and the fundamental principles by which we shall be guided in dealing with acute general peritonitis of the type under consideration.

Let us see what our patient's condition precisely is at the onset of his malady, that we may the better learn what the therapeutic indications are:

First. He is suffering from bodily weakness; he sleeps little and has lost his appetite. The heart's action is feeble and accelerated. The temperature is elevated. He is in constant pain, of varying intensity. He is in a melancholy state of mind. There may be more or less thirst. He lies on his back with his knees raised. Coughing, sneezing, sighing, or bodily movement increases his distress; hence his abdominal and thoracic muscles are more or less fixed, and he respires with short, shallow gasps. The belly is hard and flat, though in cases of great gravity it may be tympanitic. The bowels are closed and urination may be difficult or impossible.

The integument and subcutaneous tissues, over the ventral regions, anteriorly, especially, are extremely sensitive to pressure; and the cellular membrane, immediately beneath the skin, along the muscular planes, is the seat of a free inflammatory exudate.

Clearly, our first move will be to place our patient in such a condition as to best resist the violence of the disease and prevent it from making further progress. Here we will find that to a large extent, nature has anticipated us. The body is



in a state of rest; secretion is in abeyance. The inflamed muscular coat of the intestine is paretic, and hence peristalsis has mostly ceased. Digestion for the time is impossible, and we are warned not to force it, by the persistent loathing for food, which is always present.

The system craves liquids, but the stomach will not tolerate them in large quantities.

The first indication in the acute stages of peritonitis, will be to relieve pain.

It is my conviction that it is of no consequence what the agency be which we employ for this purpose, provided, its use will not seriously jeopardize life. Hence, why, not infrequently, free leeching of the abdominal parietes, the application of moist heat, sinapisms, or blisters, often act in a prompt and salutary manner. And, if not alone, they will in conjunction with other remedies, serve a most useful purpose.

When, however, the pain is of an aggravated character, we must employ a drug which will quickly ameliorate or wholly control it.

For this purpose there is nothing in the pharmacopœia that will equal opium; for it serves in a marvelous manner, many important purposes: (1) as an analgesic; (2) as a narcotic; (3) as a mental exhilarant. Authors have been said to employ it to "lock up the bowels" and to "splint the intestines." This is "far-fetched" and without any foundation in fact; for, from the onset of the malady, the intestine is crippled, and constipation is the rule. So continuous and protracted is this, that of late, since the abdominal incision is regarded as so trivial a matter, there are cases reported where the inexperienced have mistaken this [paretic state of the intestine for internal obstruction and opened the abdomen, to find nothing.

Nor is any splinting necessary, but rather relaxation; for the inflamed and infiltrated abdominal walls, in a state of spasmodic contraction, hold the visceral contents in a tight grip.

Opium is the ideal remedy here, for it buoys up the spirits and relieves pain; secures to the patient ample sleep. What it accomplishes toward the full restoration to health beyond this is in an indirect manner.

Unhappily, however, the free administration of opium and its alkaloids is full of danger in the hands of the incautious, or inexperienced. Idiosyncrasies must be watched for and the cumulative action of the drug guarded against. It should be always administered hypodermically, commencing with small doses. For its full therapeutic effect, the drug must be given freely and frequently. This necessitates a large sacrifice of time on the part of the medical attendant. And if he is not ready to make it, then his patient's chances of recovery will be better by the employment of some other remedy, attended with less risk to life.

Opium, though without a rival in peritoneal inflammation, yet after all in itself serves but a subordinate purpose; for the relief of symptoms only. It makes no impression on the underlying pathological process, but may, through masking symptoms, give rise to delusive hopes, so that the patient may imagine himself out of immediate danger, while mortal changes, only too manifest to the medical attendant, declare the approaching end.

Mercury, since time immemorial, has been known to exert a specific action on inflammation.

In the inflammation of serous membranes, if administered with energy and intelligence at the onset of the attack, it stands unrivaled, serving the double purpose of arresting the plastic exudate and hastening its absorption. In conjunction with opium, it constitutes a sovereign remedy. Simultaneously with opium its administration must be commenced. Nor should we be deterred because, when excessively or injudiciously employed, salivation or its toxic action may occasionally occur. Used with proper discrimination and judgment, this painful complication should seldom or never arise. As the stomach is extremely sensitive in peritoneal inflammation, the most effectual manner of administering the mercurial salts will be either by hypodermic injection or by inunction. It must be unsparingly employed, in all cases, until one of three things is distinctly manifest: 1st, that its therapeutic effect has been partly attained; 2d, that symptoms of ptyalism are present, with no abatement of the disease; and 3d, when signs of approaching dissolution are evident.

In diffuse, acute peritonitis, then, opium to secure comfort and mercury as an antiseptic, if you like, or antagonistic to those toxic, lethal elements in the blood, which in high fever always paralyze cardiac impulse.

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## Proceedings of Societies.

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### NEW YORK ACADEMY OF MEDICINE—SECTION ON ORTHOPEDIC SURGERY.

STATED MEETING OCTOBER 16, 1891.

Dr. Royal Whitman presented a patient, illustrating the application of a brace for the more perfect fixation of the spine in disease of the middle dorsal region. The appliance consisted of two saucer-shaped pads covering the prominence of the shoulders, connected by an unyielding steel bar, passing across the chest; and two triangular hard rubber pads covering the lower two-thirds of the scapulæ, connected by a steel bar. The Taylor back brace was applied as usual, and the back bar attached to its upper portion. The shoulders were then pressed back to their full limit, the front pads placed in position, and firmly attached to the brace of straps passing above to the neck bar, and through the axillæ to the back pads which held the scapulæ against the thoracic wall. Motion of the spine was thus confined entirely to the neck. Although the necessary movements of the arms were not restricted, forward reaching movements, which were always accompanied by flexion of the dorsal spine, were entirely prevented. This principle, the restraint of certain movements of the arms which tended to increase the existing deformity, was the point to which he wished to call the attention of the society, as he was not aware that its importance had before been insisted on.

Dr. R. H. Sayre fully agreed with Dr. Whitman as to the necessity of keeping the shoulders back in this class of cases, but the difficulty hitherto had been to maintain such apparatus in proper position. In a paper which he had read at the re-



cent meeting in Washington, he had called attention to the fact that then the disease was situated high up in the dorsal region, the plaster of paris jacket did not give proper support, because it failed to hold the shoulders back, and that in such cases he was in the habit of employing pressure backward on the tips of the shoulders.

Dr. Newton M. Shaffer thought that the apparatus exhibited acted admirably in fixing the shoulders, but it was open to the grave objection that by exerting pressure on the scapular plates in this way, the uprights are prevented from exerting the proper amount of pressure at the seat of the disease, and so the apparatus was not able to arrest the traumatism of respiration. He thought this was a defect inherent in the apparatus, and not, as Dr. Whitman believed, simply an accident, due to improper fitting of the brace to the patient's spine.

Dr. Whitman replied that he thought the apparatus exerted all the pressure that the skin would bear, and that by slightly modifying the curve of the uprights, the defect noticed by Dr. Shaffer would disappear. His object in presenting the apparatus was to elicit a discussion on the question, whether or not it was desirable in this particular class of cases to attempt to control the forward movement of the shoulders.

#### BOND'S OPERATION FOR TALIPES VALGUS.

Dr. A. M. Phelps presented a young man whom he had been treating for a number of years for a very severe case of Talipes Valgus. Almost all methods had failed to give more than temporary relief, although in one instance there was no relapse in the case for a whole year. The patient constantly wore a support for the arches during the time.

The patient sought relief not so much on account of the deformity, as because of the severe pain which he suffered, and which prevented him from standing on his feet; without shoes, he could hardly walk. His occupation was printing.

In conversation with Dr. Bond of Westminster Hospital, London, England, Dr. Phelps had learned of the operation which, in its author's hands, had been successful.

The operation performed by Dr. Bond was for the purpose of relieving the pain, which it certainly does. He alluded to the operation, as "firing," the same as is done for the relief of spavin in a horse.

The operation consists in making transverse incisions with a Paquelin cautery, beginning at the inner malleolus, and extending one-third of the distance across the sole of the foot, cutting through the cellular tissue down to the muscles. About four of these incisions suffice. Two semi-circular in-

cisions are made, crossing the transverse ones. It seemed to Dr. Phelps that if the arch of the foot, before the operation is performed, were well shoved up in place, and held with plaster of paris for a few weeks, that the shortening of the tissues in the sole of the foot by cicatricial contraction would be more effectual, and would hold the arch in the normal position.

The operation when applied in this manner for the purpose of shortening the girders of the arch of the foot is identical in principle with an operation which Dr. Phelps performed and reported to the American Orthopedic Association in 1889.

The objection which has been urged against the open incision methods for talipes equinus is that the scar is quite likely to be sensitive, and it is interesting to note that in this case, the amount of the scarring being considerable, the patient walks upon the scarred tissues without any pain, and is able to work at his trade. The only support to the foot needed is an ordinary shoe, slightly thickened on the inner side.

Dr. R. H. Sayre said that the amount of pain experienced in these cases of flat foot bears no relation to the amount of deformity. This patient's foot is still turned outward, and as in many other cases when the foot is brought into the normal position, there is a very noticeable involuntary twitching of the peroneal muscles. The patient had been made comfortable once before for a period of a year, so that it was entirely too soon to say that the case would not relapse. As the arch of the foot is in large part maintained by the deeper structures, it seemed doubtful whether the scar tissue, which did not go beneath the muscles, would be sufficient to hold up the arch, although at present it did this very well.

Dr. A. B. Judson said that in view of the well known fact that cicatrices after burns contract persistently and with great force, the operation was not only ingenious, but quite likely to prove successful.

Dr. Whitman thought the operation absurd and extremely unscientific. No case of flat foot is cured until the important movement of abduction is perfectly free to its utmost limit. In the present instance abduction is not possible, and the case is only relieved, not cured. The only way to cure flat foot is by increasing the power of the muscles which support the weak portion of the foot.

Dr. Halsted Myers said that as the pain in flat foot is largely due to periostitis about the attachments of the ligaments involved and in the joint structures themselves, this operation with the Paquelin cautery might act beneficially by counter-irritation, just as it does in many cases of joint disease else-

where. Relief from pressure during the healing of the wound was also an important factor in the cure.

The president stated that if this procedure of Mr. Bond gave permanent relief from pain, it would constitute a valuable accessory to our methods of relieving this troublesome symptom. In working people, in whom this deformity occurred most frequently, the question of a perfectly formed or imperfectly acting foot was secondary. What patients wanted was first, relief from pain, and secondly, feet that would give them an opportunity to earn a livelihood.

Dr. Phelps, in closing, said that the case was not presented as a cure for the deformity of hallux valgus, but that the flat feet seemed to be cured.

He had never observed periostitis in cases of flat foot, but he had frequently seen inflamed medio-tarsal joints, the result of pressure, and even the growth of new bone about the joints precisely as is seen in severe forms of lateral curvature.

The scaphoid bone is really the key-stone of the arch, and when it is dislocated downward by the lengthening of the tissues in the sole of the foot, it causes great pressure. The patient will experience pain. This pressure, long continued, results in inflammation and growth of bone about the joint.

He thought it more scientific to shorten the girders of the sole of the foot than to do an osteotomy.

#### A CASE OF MULTIPLE JOINT DISEASE.

Dr. R. H. Sayre presented a little boy who had had a strange combination of diseased joints, without any rheumatic history.

When about two years old the boy had a severe attack of scarlet fever, which was followed by an ischio-rectal abscess and double otitis media, which still continues. About ten months after the attack of scarlet fever he fell, and shortly afterward the left knee became swollen and tender. A splint was applied and the knee soon appeared well. Shortly after this the right knee and the right hip joint became successively inflamed. He was then treated for about a year by traction, first in bed and afterward with a long traction hip-splint. After this, the left knee, the right knee and the left shoulder became successively inflamed, and so severe was the inflammation in the shoulder that at one time it was almost completely ankylosed. In 1888, after an injury, the right knee and right hip became swollen and tender, and it was at this time that the case first came under his observation. After the flexion had been overcome, a splint was applied, which produced traction on both the knee and hip joint. Photographs were exhibited



showing the case with the splint applied. Last July it was considered safe to remove the splint. At present he has no pain, extension is good, and flexion can be made to a right angle. There is almost perfect motion at the hip joint. He had looked upon the joint lesions as probably tubercular, but it was possible they were metastatic.

Dr. H. L. Taylor did not believe the joint lesions were tubercular.

The President also thought the whole clinical history pointed away from tubercular disease, and that the scarlet fever had probably given rise to a rheumatoid condition.

Dr. A. M. Phelps said the trouble was either rheumatic or metastatic, and as the joints did not suppurate, the former was the more probable origin. While the application of the splint probably assisted in bringing the case to so favorable a termination, it was quite likely that constitutional treatment alone would have been sufficient. He had been misquoted with reference to the occurrence of flexion at the hip joint. Where the *whole* number of case have been reported, he believed the statistics would show that not 5 per cent have recovered without angular deformity, yet he believed that not one single case of hip joint disease need recover with angular deformity.

Dr. Sayre said that it was not material to this discussion whether the joints were tubercular or septic. The point he desired to bring out was, that no matter what the nature of a long-continued inflammation of a joint, protection of that joint is necessary. He agreed with Dr. Phelps that no case of hip joint disease ought to have angular deformity.

#### AN UNUSUALLY SEVERE CASE OF CONGENITAL LATERAL CURVATURE.

Dr. R. H. Sayre presented such a case. The patient is now fourteen years of age, but her mother says that at birth the deformity was nearly as great as now. It was one of the most severe congenital cases he had ever seen, and she first came to him one week ago. Examination at that time showed that between the lower and upper ribs was a large V-shaped gap through which the liver could be felt. At the age of six years, she had pneumomia, and shortly after this an abscess, which was probably connected with the pleura, opened through the right thoracic wall. Her breathing is puerile; there is no cardiac lesion. At the time of her birth the child presented transversely, and the labor was difficult, so that it was possible that this may have had something to do with the deformity. He thought all the ribs were present. When first seen, her height was four feet six and three-quarter inches. but after

being suspended there was a gain of five-eighths of an inch. He desired to call particular attention to this increase in the height as the result of the suspension. In another case, between September 5 and October 15, there had been a gain of three-fourths of an inch; in another, there was also a gain during a month of treatment of three-fourths of an inch. and in still another, which measured before treatment four feet nine and seven-eighths inches, the measurement after about a month was five feet one and one-eighth inches.

Dr. H. W. Berg said that the mere fact that the patient had such excellent use of her limbs would show that the curvature was not due to a lesion of the brain or spinal cord. If the ribs were congenitally absent, there would be sufficient cause for the curvature without supposing any injury during labor.

Dr. Judson remarked that the case was an illustration of the fact that in lateral curvature, the kyphosis is sometimes very considerable, and may be as serious as in Pott's disease.

The President said that some years ago he had called attention to the frequency of lateral curvature in very young children, most of which he believed to be of congenital origin. He had repeatedly urged the necessity of the careful examination of infants' spines, as a matter of routine, and thus, were deformity present, an early opportunity for treatment. He believed that were this done, we should not see such distressing deformity as Dr. Sayre had presented. Quite recently, Dr. F. Beely, of Berlin, had pointed out that in these early cases of scoliosis the bones of the head were not symmetrical. The case just presented was instructive as showing how great may be the deformity in cases which have not had the benefit of early and judicious treatment. Notwithstanding the deformity develops very slowly, so many cases apply for treatment with the deformity well marked, that he was inclined to believe that a large proportion of all cases of scoliosis in children are congenital.

Dr. V. P. Gibney presented a case of hip disease showing

#### A REMARKABLE RECOVERY BY NATURE'S METHODS.

A boy of eight years was admitted to the hospital in 1882 with disease of right hip in second stage. Family history, tuberculous. Disease dated back to the previous April. On admission, he was fairly nourished, hip flexed to 100 deg., and held in this position, *Practical* shortening of three and three-fourths inches. On July 7, 1883, flexion had increased to 135 deg., and an abscess filled the whole gluteal region. On October 12 the abscess opened. November 18 he had become

greatly emaciated, pale and waxy, the thigh acutely flexed on the abdomen and abducted, the head being apparently dislocated on the dorsum, while the whole thigh from the junction of the lower and middle thirds to the trochanter major was undermined, and large quantities of pus were discharging from two sinuses. Could only sleep with the aid of two drachms of the U. S. solution of morphia, and his condition was so bad, that it was thought there was no chance of his recovery, and he was advised to be taken home. On the 27th of November he was visited by a member of the house-staff, who found him suffering from diarrhœa and night sweats, with poor appetite, a pulse of 130, and a temperature of 101 deg. On the 7th of December his condition was about the same, except that a bed-sore, as large as a half dollar, had formed over the trochanter on the sound side. Not seen again until October 14 of the present year, when he returned, looking hale and hearty. He said that, after leaving the hospital, he had been confined to bed for one year and a half, and had then begun to go about on crutches. For the past four years he had been wearing a five-inch high shoe. The site of the old abscesses and of the bed-sores are marked by very large cicatrices; the angle of greatest extension is 100 deg., and that of greatest flexion, 90 deg.; the abductors are very tense. His measurements are as follows: R. A., 27½; R. U., 30; R. T., 6 inches down, 13½; R. K., 12; R. C., 10¼; L. A., 29; L. J., 36; L. T., 6 inches down, 17¼; L. K., 13; L. C., 11¾.

#### THE NECESSITY FOR EARLY MECHANICAL TREATMENT IN INFANTILE PARALYSIS.

Dr. W. R. Townsend read a paper with this title, calling attention to the various stages, the methods of making a prognosis as to return of power and as to deformities resulting, and demonstrating the value of mechanical treatment in all stages, but especially in that before the appearance of deformity as a method of prevention.

Dr. H. W. Berg called attention to the importance of avoiding heavy apparatus, which often seriously interferes with the paralyzed muscles. In addition to this, all such apparatus should be applied from a *healthy* fixed point of support. One of the most troublesome symptoms in long standing cases of infantile paralysis is the low surface temperature. He had given relief in two recent cases by wrapping the limbs at night in cloths wrung out of ice water, and covering these with warm bed-clothes.

Dr. Whitman said that the author spoke of equinus and equino-varus as the most common deformities in untreated



cases. Equino-valgus he thought to be the most common deformity in treated cases, and it was very difficult to prevent.

Dr. Shaffer said that in the fourth stage, where contractures occur, and paralyses are very pronounced, he had met with a very surprising series of cases. He had records of four cases of equinus in adolescents and adults, where the anterior tibial muscles and the quadriceps extensor femoris were involved, and the patient sought relief on account of the deformity of the feet. He had, by means of his antero-posterior traction shoe, restored considerable power to the muscles. Another important point was the improvement in the nutrition of the feet resulting from this traction. One patient used to come periodically, as she expressed it, to "get her feet warm." Not only would the feet get warm during the application of the traction, but they would remain so for the rest of the day. He had never seen such results follow the use of electricity and massage, and similar methods of treatment, with or without tenotomy. Of course, in calcareous cases, this traction can not be applied, and hence these desirable results can not be obtained. The cause of the improvement seemed to be the peripheral nerve irritation occasioned by the traction, exerted principally upon the gastrocnemius and all the other resisting tissues. He had known the calf circumference to increase half an inch by actual measurement during a month of this treatment.

Dr. R. H. Sayre thought that one explanation of the increased power of the quadriceps extensor could be found in the fact that the feet were placed in a position where they can be used more advantageously.

Dr. Judson considered the paper worthy of much attention, and it was a matter of congratulation that the profession at large already recognized the importance of sending these cases to orthopedic surgeons.

Dr. H. L. Taylor thought that we might go even further than the author, and state that a very large majority of the deformities of the lower extremities are preventable by proper orthopedic treatment. A very badly deformed foot from slight paralysis will often prevent the use of many muscles, and even where muscular power can not be restored, proper mechanical treatment will often secure to the patient very respectable locomotion. Mechanical treatment, by enabling the patient to go around more naturally, will often increase the warmth of the limbs, but for very bad cases he had for a long time made use of hot, dry air, or of two woollen stockings, one underneath and the other over the brace, to keep up the proper temperature over the parts.

The President said that it was a popular idea that braces tend to bring an increased weakness of limbs and various dis-

orders, and until recently the great obstacle to beginning mechanical treatment in the early stages has been the opposition of parents and of the attending physician. Within the last year he had seen two or three cases quite early, and had noticed a stage of tenderness, which might possibly prove a temporary contra-indication to mechanical treatment. He did not think this condition had been mentioned very generally by orthopedic writers.

Dr. Whitman said that he had many times met with this condition.

Dr. Townsend, in closing the discussion, said that he thought much of the opposition to braces arose from the fact that orthopedic surgeons were not agreed among themselves as to what kind of apparatus was most suitable for the treatment of the different classes of cases. He desired to emphasize the importance of that part of the paper which refers to the experiments of Mr. Young on electrical examinations of muscles. If by such an examination, one could ascertain that in a given case contractures and deformity would result, the task of persuading parents to allow their children to receive early orthopedic treatment would be a much easier one than now.

#### ADAMS COUNTY MEDICAL SOCIETY.

NATCHEZ, Miss., Nov. 13, 1891.

*Editor New Orleans Medical and Surgical Journal:*  
The Adams County Medical Society met at the office of Dr. N. L. Guice on Tuesday, Nov. 3, 1891.

The committee appointed at the last meeting to draft a fee bill, made report through Dr. L. H. Lamkin.

The entire session was given up to the consideration and revision of same.

Below are given the fees for the ordinary work:

Day visits within limits of City of Natchez, \$2.50.

Night visits within limits of City of Natchez, \$4.00.

Office consultation and examination, \$2.00 to \$10.00.

Visits to country, \$2.00 for first mile and \$1.00 for each succeeding mile or fraction thereof.

The secretary was authorized to have a sufficient number of printed copies made and forwarded to each member of the society and physician of Adams County.

The reading of Dr. Hall's paper was deferred until the December meeting.

Dr. L. H. Lamkin was appointed as assayer for the January meeting.

The meeting then adjourned.

P. BECKMAN, M. D., *Secretary.*

The Mississippi Valley Medical Association held its Seventeenth Annual Session at St. Louis October 14, 15 and 16, 1891, President Dr. C. H. Hughes, of St. Louis, in the chair. The attendance was large, the papers numerous and valuable. Dr. I. N. Love, the incomparable chairman of the committee of arrangements, and his able assistants, deserve unstinted praise for their provision of receptions, rides, dinners, suppers, banquets, fine weather and full moon. Dr. C. A. L. Reed, of Cincinnati, was elected president; Dr. E. S. McLee, Cincinnati, re-elected secretary; Dr. C. S. Bond, Richmond, Ind., first vice president; Dr. J. H. Stucky, Louisville, second vice president; Dr. Joseph Ransohoff, Cincinnati, chairman committee of arrangements. Place of meeting, Cincinnati, October, 1892.

The next annual meeting of the American Health Association will be held in the City of Mexico, commencing Nov. 30, 1892. It is expected that arrangements will be made whereby especially low transportation rates will be secured, so that the expense incurred by members residing in the United States and Canada in attending the meeting, notwithstanding the greater distance, will not greatly exceed that of former meetings. The great interest and activity exhibited in public health matters by the delegates from Mexico indicate that this meeting will be made one of unusual interest and prominence. Papers will be received, under the by-laws, upon any subject relating to the public health, but the executive committee have voted to invite, and give preference to, papers on the most dangerous communicable diseases. The association will hold its meeting in 1893 in the city of Chicago, and, so far as possible, the occasion will be made an international congress of hygiene and public health.

#### THE CHATTANOOGA MEDICAL COLLEGE,

a school requiring three years' study, has now entered upon its third year of good work and earnest efforts on the part of both faculty and students. Their number is now 102, good and faithful men.

**A CREMATORY IN TROY.**—The new crematory to be erected in Oakwood Cemetery, Troy, the gift of Mr. Wm. S. Earl, will probably cost \$150,000. It is to be of granite, 136 feet long and seventy feet wide, and will be a mortuary chapel and retort.



## Correspondence.

*Dr. A. McShane, Editor of the New Orleans Medical and Surgical Journal:* DEAR SIR—Permit me to answer the editor of the *Medical Standard* of Chicago, through your columns, in regard to his comments upon the report of the monster, that I have purposely worded the sentence in such a manner as to show that the monster was not altogether dead in spite of all abnormal conditions, and, besides, to create a discussion upon the subject of children born alive; but, as that gentleman's conscience seems to be materially disturbed, I will state for his benefit that said monster never uttered a sound; that it made two or three convulsive movements with its *left leg* only. About turning it over and away from me, it was in consequence of that horror which I felt, and which I shall never forget, when I received the subject in question into my hands. Being born alive and being viable are two widely different states of affairs.

Ask that gentleman to please read that article and cut *carefully*; then he will find that life in this instance was out of the question; that all conditions were abnormal; that there was dropsy of the amnion-fluid: that the fœtus was born before maturity; that the cerebrum attached to the base of the skull was about as large as half of a hen's egg; that there was no cerebellum at all, but, instead of it, only some bloody serum. The monster, as I said in my report, was rigid, such that you find in a body in which rigor mortis had fairly set in; and, if that gentleman wishes, I will send him the photographs, upon which he can see *lock jaw* plainly pictured, although he could not do so upon the cut.

Si tacuisses.....

Respectfully yours,

H. J. GABERT, M. D.

We learn with great pleasure that the Minister of Public Instruction has selected our distinguished friend, Dr. E. J. Moure, founder and editor of the "*Revue de Laryngologie, d'Otologie et de Rhinologie*," to deliver an official course of lectures on diseases of the ear, nose and throat at the Faculty of Medicine of Bordeaux.

This appointment will certainly meet with general approval in France, where the newly elected professor is considered as one of the ablest representatives of his specialty. His numerous friends and admirers abroad will also recognize this official reward as a deserved compliment.

Dr. E. J. Moure is the founder in Bordeaux of the first special clinic (outside of Paris) for the treatment of diseases of the ear, nose and throat. Several of his chiefs of clinic have already acquired in Bordeaux, Boulogne, Paris and Marseilles an enviable reputation, which they owe to the teachings of their professor.

His works on diseases of the nasal fossæ and naso-pharyngeal cavity; his lectures on diseases of the larynx; his study on laryngeal cysts; his translation of Morell Mackenzie's book, and numerous other scientific memoirs, have rendered his name familiar to all interested in the study of this specialty.

All fair-minded physicians, and those interested in medical education, will gladly welcome this appointment, from the fact that it is the first official recognition by the Faculty, and by the Government, of the importance of otology, rhinology and laryngology, as special branches of medicine.

Unlike Germany, Austria, and most other countries, France has been very slow in establishing special chairs in her Faculties. But now that, in Paris, men like Fournier, Guyon, Ball and Panas have successfully removed the narrow-minded opposition of the official Faculty and have led to the creation of chairs on their specialties, let us hope that the appointment of Dr. Moure, in Bordeaux, is but the entering wedge which will induce the Faculties of Paris, Lyons, etc., to create similar chairs. France will have then no cause to envy her neighbors, and will be fully able to retain a large number of foreign students, who, ignorant of the great private facilities of Paris, flock every year to Vienna and Berlin on account of the official recognition given in their Faculties to these special branches of medicine.

A. W. deR.

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## Editorial Articles.

"LYSÆMIA," THE LATEST ADDITION TO MEDICAL NOSOLOGY.

It has been well said, that he who finds a suitable name for a complex of symptoms renders a service upon the human race. The latest member of the medical world to deserve this distinction is Dr. E. H. Martin, of Green Grove, Mississippi.

The Southwestern States have been the scene for some years of a form of malarial fever that is remarkable for its most prominent symptoms—hæmaturia—and also for the great mortality attending it. The medical journals of these States contain many articles upon the subject, but until recently it can hardly be said that they threw much light on the disease, or helped to lower the mortality. The literature of malarial hæmaturia is colossal—one indication that the malady was not well understood. During the past few months, the JOURNAL has contributed its share to the general fund of knowledge, and it feels that the modes of treatment advocated by the writers are all based upon sound logic. Modern medicine demands a rational treatment—a treatment based upon a clear



comprehension of the pathological conditions to be corrected. Where these are clearly made, remedies of known powers can be applied to restore the system to the normal.

The latest of the articles on this subject that the JOURNAL presents to its readers (published in this number) is evidently the outcome of careful thought and wide experience. It is a paper which should be carefully read by all physicians practising in localities infested with malaria. Dr. Martin has quite clearly made out the pathological condition, and has rationally applied his remedies to correct it.

The derivation of Dr. Martin's appellation (*lysæmia*) for the old-time "malarial hæmaturia," is given in his paper. "What's in a name?" A great deal. A well-selected name for a disease will indicate the dominant pathological condition, and may serve as a guide to the plan of treatment to be followed. Dr. Martin's term very aptly indicates the debased condition of the blood, which is the chief factor in "malarial hæmaturia;" and it further emphasizes the importance of purifying and *reconstructing* the circulating fluid. That the therapeutic indications thus outlined are fully met is amply shown by the results of Dr. Martin's plan of treatment.

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"*Lysæmia*," however, is not confined to the Southwestern States. Italy has been the scene of many deaths from this formidable disease. In THE NEW ORLEANS MEDICAL AND SURGICAL JOURNAL, February, 1889, there appeared a translation of an article by Dr. Tomasselli, of Catania, on a condition which he labeled "Ictero-hematuric Fever from Quinine" (quinine intoxication). Tomasselli's article is well thought out. The pathology is exhaustively considered, but the details of his plan of treatment are lacking. Dr. Martin's paper admirably supplements Tomasselli's in this respect.

Dr. J. W. McLaughlin, of Austin, Texas, has also in the same volume of THE JOURNAL (March, 1889) a paper on "Hæmorrhagic Malarial Fever." The doctor briefly sketches the history of the disease, the first case of which was observed in 1794. The disease has prevailed largely in the Southern States since the civil war, and, as Dr. McLaughlin remarks, "the most valuable literature upon the symptoms and treat-

ment of hæmorrhagic malarial fever that has been published since 1865 is to be found in our Southern medical journals." Dr. McLaughlin entertains some original views upon the pathology of the disease. The reader is referred to his article, which is in keeping with the other productions of his scholarly pen.

#### ELECTION OF RESIDENT SURGEONS AT THE EYE, EAR, NOSE AND THROAT HOSPITAL.

At the meeting on the first Wednesday in January, 1892, the executive committee of the Eye, Ear, Nose and Throat Hospital will elect two resident surgeons for the ensuing year, the appointees to enter upon their duties immediately after their election. Physicians desirous of availing themselves of the unusual facilities offered by this institution should send in their applications at once to the secretary, Mr. Jos. A. Hincks, 23 South Rampart street.

## Abstracts, Extracts and Annotations.

### SURGERY.

#### \* SURGICAL TREATMENT OF PILES.

On the basis of 200 cases of operation on hemorrhoids, Allingham (*Medical Press and Circular*, 1891, No. 2724) discusses the surgical treatment of this disease.

He divides hemorrhoids into two groups: the first including those which come down at stool, and those which are almost always in a state of prolapse and bleed profusely at each act of the bowel. In this class of cases the quickest operation is the best, since as a result of long-continued hemorrhage there is always considerable anæmia, and therefore it is of prime importance that as little blood as possible should be lost from the operation, and that there should be a minimum of risk of secondary hemorrhage. These requirements are ful-

filled by the ligature, which can be applied in a very few minutes, and is practically free from any danger of after-hemorrhage.

The second group comprises those piles which are chiefly troublesome because of the inconvenience they occasion, since they are prone to come down and prevent the patient taking any active exercise. These piles rarely bleed, and do not otherwise interfere with the enjoyment of good health. Here the great point is to select the least painful operation. The best modes are crushing or simply cutting off the piles and picking up any vessels that may bleed.

In the operation of ligation with incision the pile is drawn down by a vulsellum and separated from the muscular and submucous tissues upon which it rests. The incision is made upon the skin at the junction of the mucous membrane, and is carried up the bowel, so that the pile is left connected by vessels and mucous membrane only. A strong silk ligature is then tied as tightly as possible, and the ligatured pile is returned within the sphincter.

This method is very well suited to piles which are large and vascular, and are inclined to be sessile rather than pedunculated. It should be applied to patients who have any tendency to cardiac or kidney disease, or where there is a thrombosed condition of the vessels. It is the best to use when patients are feeble. Ligature is, in fact, the safest operation. Its drawbacks are that the wound takes some time to heal, there is more pain after operation, and on the first motion of the bowels, than after crushing or simple excision. There is more sloughing or suppuration until the ligatures have separated, and hence there is greater liability to some contraction.

The crushing operation consists in drawing the pile by means of a hook into a powerful screw-crusher, which is tightly screwed up, and distal end of pile cut off. The crusher should be applied on the longitudinal aspect of the bowel, and should be left on the pile for about two minutes. This operation should be used when the piles are medium-sized and rather pedunculated, and the patients are in good health; but in bad cases it is not so safe as the ligature. In ordinary cases its advantages are that there is freedom from pain after operation; retention of urine is of rare occurrence; suppuration is not likely; there is little or no pain on the first action of the bowels, and recovery is usually rapid; after-contraction is not common. The clamp and cautery are not favored by Allingham. He states that statistics show that it is quite six times as fatal as ligature or crushing; and burning gives more pain after operation, as is the case with all burns. Hem-



orrhage is more likely to occur; there is greater sloughing of the rectal tissue. More time is required for healing, and greater contraction is common, as is also the case with all burns. The excision of piles is best applied to one prolapsed pile, to the single perineal pile, so common in women, or to one pile which is complicated with fistula, ulcer, fissure, etc. As a rule, one or two vessels require clipping. It is, therefore, inexpedient to excise many piles, for there may be trouble in picking up the divided arteries.

Allingham believes that Whitehead's excision method—that is, removal of the entire pile area and stitching of the healthy bowel above to the sphincter—is rarely necessary. It is a slow and bloody operation, and is at times followed by contraction. Few cases are really well under three weeks after operation, and premature resumption of the ordinary ways of life may cause a greater tendency to contraction, or, what is worse, troublesome and tedious ulceration may supervene and take months to heal.—*Am. Jour. Med. Sciences.*

#### THE TREATMENT OF COMPLETE PROLAPSE OF THE RECTUM

Harrison Cripps\* believes that while it may be necessary for the cure of complete prolapse of the rectum, occasionally to resort to complete excision, that, as a rule, the use of lineal cautery is founded upon sound physiological principles attended with very slight risks.

“Since prolapse is due to the slipping of one coat of the bowel on the other, together with want of sufficient rigidity in its walls to prevent invagination, the binding the muscular and mucous coats together, and at the same time stiffening the walls by inflammatory deposit, would seem to be plainly indicated. An exudation artificially produced in the submucous tissue meets this indication by cementing the coats firmly together, thus effectually preventing slipping, and at the same time giving the bowel sufficient rigidity. The actual cautery is admirably fitted to produce an abundant inflammatory exudate. Before performing the operation the bowels should be thoroughly emptied. The patient should be anæsthetized and placed in lithotomy position. If possible, the prolapse should be made to protrude: four lines of cautery are then drawn along the bowel in its long axis. These lines should begin well within the canal of the bowel at the apex of the protrusion and terminate at the anal margin: they should be about one-

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\*Lancet, vol. 11, No. 15, 1890; American Journal of the Medical Sciences, vol. ci, No. 5, May, 1891, p. 516.

quarter of an inch in width, and deep enough to thoroughly sear but not actually destroy the mucous coat. Where the cautery lines cross large veins these should be tied on each side by passing a threaded needle beneath and knotting. If much time is spent in the operation swelling will take place and the reduction will be difficult.

“ In case the prolapse cannot be made to protrude, the bowel may be cauterized *in situ* by using the duck-bill speculum, which may be shifted when necessary. The actual cautery is most satisfactory, since Paquelin's instrument is too hot when first applied and loses heat too readily. After operation a thick india-rubber tube one-third of an inch in calibre and seven inches in length is passed into the bowel for five inches. Strips of oiled lint are then packed around the tube, extending as far as possible into the bowel. Cotton-wool well dusted with iodoform is finally packed into the tube and in and about the anus: thus firm support is given and at the same time the escape of flatus is not prevented.

“ Special care must be taken to prevent the descent of the bowel during the early stages of healing. In forty-eight hours the first dressing is removed, the parts are washed, and a clean dressing is applied.

After the first few days the dressing can be dispensed with, but the tube is retained for ten days. During this time the bowels should be kept locked by small doses of opium. Evacuation is finally accomplished by means of castor oil and enemata. The patient must not be allowed to strain, and must empty the bowel while lying on his side with the anus drawn a little from the middle line. This should be enforced for at least six weeks, during which time the consolidation is taking place.”—*Boston Medical and Surgical Journal*.

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#### MILLIKEN (S. E.) ON THE TREATMENT OF HYDROCELE BY CARBOLIC INJECTION VERSUS THE RADICAL OPERATION.

The cutting operation of Volkmann, and its various modifications, he said, while usually successful in relieving the hydrocele, requires the use of an anæsthetic, and necessitates confinement to bed for a week or more if suppuration occurred. The method of Levis, by carbolic injection, was practically painless, confinement to bed was in no sense essential, and unless an inordinate amount of carbolic acid, more than thirty minims, was used, sloughing ought never to occur. The simplest and most efficient apparatus for the purpose was a small trocar and a hypodermic syringe. After thorough evacuation,

the syringe was screwed on to the canula, and the injection could thus be made without a single drop of the acid coming in contact with the skin of the scrotum. When from 5 to 25 minims of pure carbolic acid was distributed over the whole serous surface (two or three minims in each place), nothing more than a sense of warmth was experienced by the patient. After removal of the canula slight kneading of the sac might be made to insure coating of its walls with the irritant.

Of 54 cases thus treated by Dr. Milliken at the Hospital for Ruptured and Crippled, nine were never seen after the injection, five paid one visit within the first week only, and four are at present under observation. All the remaining 36 cases could be set down as completely cured; and of these, 27 had one injection; four, two injections, and five, three injections. In no case had sloughing occurred, and not one of the patients lost more than 24 hours from business. From two to six weeks were necessary for absorption of the exudation to take place, and thickening of the sac might remain much longer than this.

The conclusions reached by the author were as follows:

(1) Carbolic injection is a safe method for the cure of hydrocele.

(2) It is practically painless.

(3) The patient can attend to business without more than one day's delay.

(4) The disagreeable effects of an anæsthetic are avoided.

—*Boston Medical and Surgical Journal*, September 10, 1891.

#### A PIN SWALLOWED PASSES PER URETHRAM.

K. D., aged five years, while playing with a bent pin in her mouth, suddenly caught her breath and drew the pin into her throat. It lodged in the fauces, but, upon her mother attempting to remove it, was dislodged and swallowed. This occurred on December 12. Fearing too great peristaltic action with a sharp-pointed foreign body in the alimentary canal, I gave no cathartics, but had the patient fed on food containing a large proportion of excrementitious matter and the stools constantly examined to find the pin if it should pass. Ten days elapsed, and, nothing having been seen of it, I had about concluded it had imbedded itself in some of the intestinal folds, or been overlooked in the dejections, when the father called to tell me that the child had passed the pin upon urinating that morning. She complained of sharp pain upon making her water, and, looking in the vessel, found the pin, somewhat corroded but otherwise just as when she swallowed it.



The passage of the pin through the intestinal wall is not so remarkable as its passage from the bladder after it had once fairly entered that organ. Of course, it is possible the pin may have passed from the rectum through the vagina and not entered the bladder at all, but the child's symptoms indicated irritation of the latter organ.—Dr. J. P. Tuttle in *New York Medical Journal*.—*Physician and Surgeon*.

#### FAIDHERBE (A.) ON CANCEROUS ULCERATIONS OF THE NOSE HEALED BY APPLICATIONS OF THE CHLORATE OF POTASH.

The patient was a woman of seventy, who had been well up to her sixty-second year, at which time a reddish tubercle, which later broke down and caused a spreading ulcer, appeared on the dorsum of the nose. When first seen, there existed an ulcer two centimeters by five, which was the seat of lancinating pain, and bled at the slightest touch.

Compresses wet with a saturated solution of the chlorate of potassium were ordered, and fourteen days later, cicatrization having commenced, applications of the chlorate in powder were added.

The sore speedily healed and remained so almost a year, when it broke out again slightly, yielding again promptly to the same treatment.—*Four. des Sci. Méd. de Lille*, Aug. 28, 1891.—*Építome*.

[Applications of an ointment containing ichthyol or aristol have produced the same effect, which is only transitory. Curretting or destruction by caustics or the actual cautery is the only method of curing it permanently.—EDITOR.]

### MEDICINE.

#### NEW YORK PASTEUR INSTITUTE.

##### SECOND YEAR—FIRST SEMI-ANNUAL REPORT.

Dr. Paul Gibier, Director of the New York Pasteur Institute, reports October 26, 1891, the results of the preventive inoculations against hydrophobia performed at this institute during the first six months of the second year of its existence (February 18, 1891, to August 18, 1891). During this time 415 persons, having been bitten by dogs, cats and other animals,

applied for treatment. These patients may be divided in two categories:

1. In the case of 345 of these persons it was demonstrated that the animals attacking them were not mad. Consequently the patients were sent back after having had their wounds attended to during the proper length of time.

2. In 70 cases the anti-hydrophobic treatment was applied, hydrophobia of the animals inflicting bites having been evidenced clinically, or by inoculation at the laboratory, and in many cases by the death of some other persons or animals bitten by the same dogs.

Indigents have been treated free of charge.

The persons treated were: 17 from New York, 16 from New Jersey, 11 from Massachusetts, 5 from South Carolina, 5 from Texas, 3 from Connecticut, 2 from Maryland, 2 from Missouri, 1 from Ohio, 1 from North Carolina, 1 from Michigan, 1 from Pennsylvania, 1 from Rhode Island, 1 from Arkansas, 1 from Virginia, 1 from Mexico, 1 from West Indies (Curaçao).

#### DEATH BY HYDROPHOBIA AFTER TREATMENT.

Miram L. Adams, five years old, of South Framingham, Mass. Badly bitten July 14 last in nineteen places by a dog recognized to be mad. Treated from July 15 to August 1. Symptoms of hydrophobia appeared six days later (August 6). Died August 9.

Three other persons (two sisters of the patient and a man bitten by the same dog) who received the same course of treatment are now enjoying good health.

This, so far, is the only death by hydrophobia out of the 255 cases treated at this Institute to date.

#### THE ADMINISTRATION OF GUAIACOL IODIDE BY THE INTESTINES.

By WILLIAM H. GREGG, M. D., New York.

The use of antiseptic remedies in the treatment of consumption seems to offer the only hope of cure or abeyance in this intractable disease. When we speak of cure we mean that about twenty-five or thirty per cent. of the cases are curable; the other seventy or seventy-five per cent. are so amenable to treatment by this class of remedies as to enable the patients to follow their ordinary business pursuits with comparative comfort for a number of years. There is no universal panacea for this disease, and invalids who are induced by sophistical theo-

ries to abandon scientific methods lose valuable time and a possible chance of recovery. Guaiacol is certainly the most active therapeutic agent we possess at the present time for the treatment of pulmonary tuberculosis, but it has to be taken in large quantities. Physicians who are satisfied with a daily dosage of a few grains—a quantity too small to produce any marked effect—need not hesitate to give by this method thirty to fifty grains without fear of overdosing, since guaiacol does not become poisonous for man until a hundred grains have been absorbed.

This method of administering guaiacol offers the greatest encouragement, for under its use the patient soon recovers weight and strength. He assumes a healthier aspect and experiences sensations of returning vigor and comfort. The cough lessens, the expectoration becomes gradually less, the pulse diminishes in frequency, and a general amelioration of the symptoms is to be observed. Perseverance in treatment is the only sure course to pursue, and offers the only hope of permanent success. The stomach is remarkably intolerant to this class of remedies, and revolts even after a few grains have been taken. Hypodermic injections enable us to introduce larger quantities into the system, but only with the greatest precaution and by fulfilling the most difficult practical conditions. The remedies must be distilled to the required degree and the instrument absolutely aseptic, and to inject the necessary quantity usually occupies two hours.

With a view of overcoming these obstacles it was decided to administer guaiacol by the intestines. In those cases where it has been carried out it has been proved that this method has no drawbacks. The signs that the drug has been absorbed rapidly make their appearance, and in the most characteristic manner. The patient tastes the guaiacol almost at once; the urine changes color and becomes greenish black or blackish. The administration of guaiacol in an enema is a simple and practical method and one to which consumptives themselves do not object, and, in a word, gives such remarkable results that the therapeutical effect of the drug is carried to its highest power. One dose in twenty-four hours is sufficient. The injection should be given at bed-time, an ordinary one-ounce hard rubber syringe being used.—*New York Medical Journal*.

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#### LYMPHATISM.

Dr. F. H. Bosworth, of New York, read a paper on the subject of "Lymphatism," a name which he could confine to



that constitutional condition under the influence of which the lymphatic glands in the neighborhood of the faucial ring become the seat of hypertrophic changes, excluding from the definition those graver cases of the lymphatic glands which constitute Hodgkin's disease and like affections, as well as those extensive lymphatic enlargements in the neck which tend to undergo suppurative changes. Manifestations of lymphatism are: enlarged faucial tonsils, adenoid disease in the vault of the pharynx, and hypertrophy of the lingual tonsil.

The object of the paper was mainly to emphasize the fact that the existence of the enlarged lymphatics in these various regions should be accepted as evidence of a constitutional taint, rather than as constituting simple obstructing hypertrophies in the throat. He furthermore insisted that, especially in the earlier years of life, before these masses have become fully and firmly organized, they were amenable to internal treatment, preference being given to the iodide of iron. He argued that this drug was almost a specific in controlling these growths, but that the mistake usually made was in giving it in too small doses. For a child 5 years old the dose should be at least  $2\frac{1}{2}$  grains, given three times daily, or half a teaspoonful of the officinal syrup. Its effects should be watched carefully, and the amount increased to 5 grains, or even more. This not only reduces the lymphatic hypertrophies, but also corrects the anæmia which so frequently attends the disease.

After the affection has lasted a few years, of course, the hypertrophies become so thoroughly organized that no internal medication serves to reduce them. In these cases, of course, the masses should be treated in the same manner as other tumors, and subjected to surgical measures; but even in the older cases, the constitutional treatment of the lymphatism, which causes the local disease, should not be neglected.—*Transactions American Laryngological Association*, September 23, 1891.—*Satellite*.

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#### SYDNEY-TURNER (A. M.) ON PARAFFIN IN DIPHTHERIA.

I have treated thirty cases (children and adults) with paraffin, and have had the satisfaction of seeing every one recover. My plan is to ask for the ordinary paraffin used in lamps, and, having scraped off the diphtheritic patch, to apply the paraffin every hour to the throat (internally) with a large camel's-hair brush. As a rule, the throat gets well in from twenty-four to forty-eight hours, and with improvement in the throat the paraffin is applied less frequently; but I continue its use for two or three days after the complete disappearance of the patches.

In three very severe cases I found that, as the diphtheria gradually disappeared, tonsilitas supervened, which I treated in the ordinary way. I find from experience that it does not do to allow the paraffin to stand in an open vessel; it seems not to have the same curative effect if exposed long to the air. It should be poured out from the can each time it is used. I can speak definitely as to the therapeutic effects, but am unable to state what the chemical action of paraffin on the diphtheritic membrane is; I can only suppose that the hydrocarbons in the liquid exert some powerful influence on the membrane. I can not see why, as the local action of paraffin is so beneficial in these cases, it should not exert an antiseptic influence if vaporized and mingled with the air in a room occupied by a diphtheria patient.

In conclusion, I would say that I have ordered a generous diet for the patient and a mixture containing tinct. ferri perchlor. and potass. chlor., to be taken every three or four hours, and that in some cases where, owing to the lateness of the hour, there was a difficulty in obtaining the medicine, the throat having been brushed diligently with paraffin, there was a decided improvement in the morning before any of the mixture had been taken, showing that the improvement was due solely to the paraffin treatment.—*Lancet*, August 29, 1891.—*Epitome*.

#### TRICHINOSIS TREATED WITH ARSENIC.

Dr. Merrill reports the case of an Italian, aged 25, whose illness dated from soon after eating Bologna sausage, about three weeks before he came under observation. Vomiting, acute pain in the stomach, and diarrhœa were the first symptoms; these were followed by a cough and a peculiar hoarseness. He seemed very ill on admission. His mouth and throat were red and dry, his tongue thickly coated, his voice husky. Physical examination of the chest and abdomen revealed nothing of importance. The urine was free from albumen and sugar. There was some diarrhœa and a little fever, but no vomiting. His arms could be but half extended, owing to the rigidity of the biceps, the fibres of which could be felt hard and tense throughout the length of the muscle; the elbow joints were swollen; and pressure on or movement of the arms caused pain. The knee joints were swollen; the legs œdematous. The muscular strength of his legs was good. The diagnosis of trichinosis was made, and confirmed a few days later by microscopical examination of pieces removed from his biceps. About this time, too, his jaw became stiff from

involvement of the masseters. Ten days after admission he was ordered Fowler's solution in five-minim doses three times a day, an additional drop to be added to the dose each day. For two or three days after this he did not improve, and seemed fatally ill, but then a change occurred. His jaw became less rigid, the œdema and pains in his limbs diminished, and he began to regain strength; and during the next fortnight he rapidly improved. The maximum dose of arsenic reached was twelve drops three times a day, but constitutional symptoms had shown themselves on more than one occasion before this dose was attained. Twenty-four days after the arsenic was ordered he left the hospital well.—*New York Med. Journ.*, September 19, 1891.—*Practitioner.*

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#### HUNTER MCGUIRE ON THE CATAPHORETIC TREATMENT OF GOITRE BY IODINE.

About six months ago he demonstrated that by means of cup-shaped electrode attached to a galvanic battery it was possible for a solution of the muriate of cocaine to be driven into the skin and complete local anæsthesia produced. A small piece of absorbent cotton, or piece of blotting paper, saturated with the solution of cocaine, was put into the shallow cup of the instrument, and the electrode attached to the positive pole of the battery. The electrode was then placed upon the skin where the insensibility of anæsthesia was desired, and the sponge on the wire joined to the negative pole was placed on some convenient neighboring part.

It required a current of four or five milliampères to drive the cocaine through the skin and make the anæsthesia complete, the insensibility extending for some distance below the surface of the skin.

A day or two after the above demonstration was made (about January 10 of this year), a case of enlargement of the thyroid gland came into his hospital (St. Luke's). The goitre was bilateral, old, very large, hard, and seriously interfered with respiration. It had resisted for years the ordinary treatment of such growths. Internally, the iodide of potash, iron, and mercury had been faithfully tried; and externally, at different times, iodine and biniodide of mercury frequently used. The goitre steadily grew; and, lately, its increase was so rapid that the lady, in great alarm, came to the doctor to ask for some surgical operation. She had spasmodic attacks of palpitation of the heart, frequent spells of giddiness or vertigo, but no ocular protrusion.



Instead of attempting the removal of the gland he determined to use iodine in the cup-shaped electrode and see what effect it would have on the growth. The doctor put in the cup of the electrode some absorbent cotton, first dipped in water and squeezed as dry as possible; and on the cotton he poured ten or fifteen drops of the tincture of iodine. The electrode, thus prepared, was placed on the most prominent part of the goitre, the negative pole on the back of her neck. The galvanic current was then turned on until the milliampère-meter showed the strength of six or eight. This current was kept up for ten minutes. While using it she said that she tasted the iodine, and afterward that this metallic taste in her throat lasted four hours.

When the electrode was removed the cotton was found simply stained with the iodine, but most of the iodine had disappeared.

This application of electricity and iodine was repeated every day for three weeks. Not always, but nearly every time she said that she tasted the iodine, and said that this was the most disagreeable part of the treatment. The tumor gradually grew smaller, at first quite rapidly, but afterward more slowly, getting more and more indurated as it contracted. The cardiac and cerebral symptoms disappeared completely.

This patient, after three weeks, was called home by the illness of her child, and did not come back for a month. The goitre, however, continued to decrease while she was absent. When she returned the applications were again made daily for three weeks. The gland was reduced to about one-fifth of the size it was when the treatment was begun, and in spite of all further use of the remedy remained stationary. But all of the subjective symptoms were gone, and the lady left in excellent health.

Two other cases of chronic goitre were treated in the same way, and with the same results, the hypertrophy diminishing rapidly at first, then more slowly, then reaching a point where it became stationary.

In four cases of recent hypertrophy of the thyroid gland in young women the enlargement rapidly disappeared under the use of these measures.

Iodine and electricity have of course been long used for goitre. As to how much of the good obtained above is due to one or the other of these agents, the speaker does not know.

Lately, in a case of pronounced ex-ophthalmic goitre, he used this treatment with quite rapid diminution of the enlarged thyroid gland and a decided amelioration of the other symptoms. The tendency to syncope and dizziness was lessened

and pulsation of the arteries diminished, but no perceptible change in the ocular protrusion resulted. The case is too recent, however, to report.—*Am. Pract. and News*, Aug. 29, 1891.—*Építome*.

#### PENTAL: A NEW ANÆSTHETIC.

Pental is a new name applied by Prof. J. V. Mering to *Trimethyläthylen*, a product of amylenhydrate heated with acids, and recommended by the distinguished clinician as a safe and effective anæsthetic. Pental is described, chemically, physically, and as to its possible utility, in the *Pharmac. Zeitung*, Oct. 7, 1891, and in the *Pharmac. Centralhalle*, Oct. 15, 1891; both journals conservatively withhold endorsement of the product, basing apparent skepticism on the fact that chemically the body has long been known, and that analogous amylens (for instance, *iso-amylen*) were employed as anæsthetics almost forty years ago, but quickly discarded because found to be unsatisfactory and offensive, owing to their unpleasant odor.

So was cocaine well-known; yet who will deny that the discovery of its wonderful anæsthetic properties was a revelation to the medical world, and worked a revolution in treatment and practice which will forever distinguish the name of the discoverer, Dr. Koller, whose publication in August, 1884, was responsible for the present universal application of cocaine?

While pental will probably not excite the same degree of interest as did cocaine, it is safe to assume—reckoning on the high character and recognized conservative authority of Prof. v. Mering—that this product will find valuable application. From reports already furnished, notably that of Prof. Hollaender, of Halle a. S. (*Therap. Monatshefte*, Oct. 1891), which was read before the Dental Section at the Convention of German Naturalists and Physicians, at Halle, this year, the new anæsthetic is shown to be suitable and efficient for minor surgical operations, and particularly in dentistry.

Pental ( $C_5H_{10}$ ) occurs as a colorless liquid, of low specific gravity; its boiling point is 38 deg. C.; it burns with an illuminating flame, and is readily inhaled without affecting the membranes of throat or passages. It is insoluble in water, but miscible in all proportions with alcohol, chloroform or ether, and being inflammable like the latter, must be protected from possible ignition. It is exceedingly volatile, but does not decompose on exposure to air or light.

The inhalations are simply conducted, 10 to 25 c. c. of the fluid sufficing, and narcosis ensues within 50 to 90 seconds (Dr. Hollaender), without influence on respiration or the action

of the heart, and causing no unpleasant side or after-effects. From a careful consideration of Dr. Hollaender's report, a most favorable impression of the pentol is gathered, and we hope to supplement and confirm this by early additional original reports.—*Bulletin of Pharmacy.*

#### METHYLEN BLUE FOR MALARIA.

A most important announcement of the specific curative effect of methylen blue in treating malaria is made by Guttman and Ehrlich in the *Berliner Klinische Wochenschrift*, No. 39, Sept. 28, 1891. The authors state that they were prompted to investigate the full action of methylen blue in malaria because of the coloring effect the product exerted on the *plasmodium malariae*, and the observation that by its infusion into the blood the red corpuscles were colored. Their expectations were fully realized, and they state that they can prove that methylen blue exerts a pronounced curative effect in malaria, and that under this treatment the fever disappears during the first day and the plasmodia are eradicated from the blood within eight days at the latest.

Only the chemically pure methylen blue (a special product for medicinal use) was employed, the dose of 0.1 gramme ( $1\frac{1}{2}$  grains) administered five times daily in capsules, and continued at least ten days after disappearance of the fever. Whether or not the dose may be largely increased is not yet decided, experiments so far not having exceeded 0.7 gramme.

The remedy induces no serious side-effects; the only unpleasant effect was a temporary irritation of the bladder, with increased desire to urinate. These symptoms were readily ameliorated by giving to the patient several doses of powdered nutmegs, a teaspoonful at a time. An increase in the amount of urine passed was also noted, but presence of albumen could not be substantiated, and the authors recommend that this be carefully looked for in the subsequent trials. After the administration of the methylen blue, the urine is colored an intense blue; the intestinal evacuations contain the coloring matter in reduced form, but on exposure to the air also quickly turn blue.

Unquestionably this paper is an important one, and the suggestion of the authors (who lack sufficient clinical material for thoroughly pursuing the investigation) that practitioners who have many malarial patients take up the subject and report results, is a good one and should be generally followed.

Care must be taken to employ only C. P. methylen blue for medical use—not to be confused with methyl blue or other similarly named anilin colors.—*Bulletin of Pharmacy.*



### WHOOPIING-COUGH TREATED BY ATOMIZATION.

Dr. H. Ernest Schmid states that he now relies entirely upon atomization for the treatment of whooping-cough in all stages of the disease. The spray which he uses is made up as follows:

R.—Carbolic acid.....	grs. vj.
Menthol, 4 per cent. solution.....	5iv.
Cocaine, 3 per cent. solution.....	5iij.
Glycerin.....	5j.
Cherry-laurel water.....	q. s. ad 5j.—M.

This solution should be thoroughly used, brutally if necessary, by an atomizer every three hours; force may be employed if necessary, and disregarding any apparant strangling upon the part of the little one during vigorous atomization, the nozzle of the instrument should be directed as far into the mouth of the patient as possible. During the struggling and sputtering and strangling some deep respirations will before long be made, and the object is accomplished. At first, in most cases, a violent paroxysm of coughing may result from the spraying, especially if much force has to be used with the child, but these soon cease and palpable effects are soon noticed by the parents. The point is to be able to impress the importance of perseverance. Dr. Schmid has seen whooping-cough arrested by this means after one thorough spraying, the cough continuing without the whoop for a while, and perfect recovery has followed in one or two weeks. From his success, he feels justified in claiming that the method promises to be more efficient than other means of treating the disease.—*Medical Record*, June 13, 1891.

### FATHER MOLLINGER.

Father Mollinger, of Troy Hill, Pittsburg, who has been long posing as priest, thaumaturgist, prophet, and medicine-man, and who is said to have accumulated \$300,000 from his miraculous cures, is somewhat in disgrace. The inevitable nemesis which awaits chicanery has come. The blow comes from the source which more than any other sustained the reverend father's sensational pretensions,—the lay press. The so-called cures have not been found. In excuse for Mollinger's practices it is pleaded that he is a regularly graduated practicing physician, and that he not only "lays on hands" but gives medicines. This, however, scarcely excuses the ceremonies of St. Anthony's day, when numberless poor and ignorant people were induced to sacrifice their property, and travel hundreds of miles for the relief of imaginary or incurable

ble ailments. That the moral tone of the proceeding is discordant with modern ideas of just dealing is the only optimistic reflection the circumstances arouse.—*Physician and Surgeon*.

#### DIMINUTION OF THE VIRILE POWER THROUGH THE INTERNAL USE OF ANTISEPTICS, ESPECIALLY OF SALICYLIC ACID.

Dr. Vanden Corput (*Revue de thérap. méd. et Chir.*, 1891), of Brussels, calls attention to the diminution of the virile power which he has observed in patients for whom he has prescribed antiseptics, such as salicylic acid, quinine, menthol and carbolic acid. The author believes that these antiseptics act upon the pigmented elements of the blood, and upon the seminal cells in the same way as upon the lower organisms. The spermatozoa became, in short, completely motionless under the microscope, just like the leucocytes, which lose their amboïd movements and cannot effect their migrations. Acid salicylic has a similar effect on the ovary, and prolongs the menstrual period.—*L'Union Medical.—Satellite*.

#### BACTERIAL PRODUCT OF TYPHOID GERMS.

Dr. V. C. Vaughan announced to the American Physiological Society at its recent meeting in Washington, that he had obtained from typhoid fevers a bacterial product, which had something of a definite chemical composition. It dissolves in water and forms an acid solution and contains no sulphur. It is highly noxious. Injected into animals it causes a rise of temperature and death. It is not yet decided whether the substance is an actual product of the germs, or whether it is not a part of the cell. Dr. Vaughan's future investigations, in this direction, will be followed with interest.—*Physician and Surgeon*

#### NAPHTHALINE AS A NEW TAPEWORM REMEDY.

According to the observations of Mirovitch (*Mercredi Medical*), naphthaline is a powerful tæniacide, being superior to other anthelmintics both in the certainty of its action and in the absence of any toxic effect. For children, the author employs the following formula:

R. Naphthaline.....4½ to 7 grains.  
 Castor oil.....½ ounce.  
 Essence of bergamot.....2 drops.

—*Indiana Medical Journal*.

## COFFEE AS A CAUSE OF PRURITUS ANI.

A correspondent thus relates a personal experience: "For many years I suffered from the most aggravated form of pruritus ani, which refused to yield to any one of the many remedies applied for its relief—nothing seemed to have the slightest effect in ameliorating the torture to which the intense itching subjected me. After exhausting the pharmacopœia I began to abstain from certain articles of food; one after another was dropped from my dietary for several weeks, but without effect until coffee was reached. An abstinence for a period of two or three weeks resulted in complete relief from the distressing symptom. As a matter of experiment the use of coffee was resumed for several days, with the effect of reproducing the pruritus; the experiment was tried several times with the same result. A year without coffee has been a year without pruritus."—*N. Y. Medical Journal*, Sept. 12, 1891.—*Epitome*.

## PIPERAZIN.

This substance is said to have the property of dissolving a large proportion of uric acid. One part of the urate of this substance is soluble in about fifty parts of water. Urate of lithia requires three hundred and sixty-eight parts of water to dissolve it; the piperazin salt is, therefore, seven times more soluble than the lithia salt. Piperazin is not toxic and not caustic, and it appears to have advantages over other substances which may be used to act as solvents for uric acid.—*Berliner klinische Wochenschrift*.

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Book Reviews and Notices.*Regional Anatomy in its Relation to Medicine and Surgery.*

By George McClellan, M. D., Lecturer on Descriptive and Regional Anatomy at the Pennsylvania School of Anatomy, Professor of Anatomy at the Pennsylvania Academy of the Fine Arts, Member of the Association of American Anatomists, Academy of Natural Sciences, Academy of Surgery, College of Physicians, etc., of



Philadelphia. Illustrated from photographs taken by the author of his own dissections, expressly designed and prepared for this work, and colored by him after Nature. In two volumes. Volume 1. Philadelphia: J. B. Lippincott Company, 1891. Pp. xxii, 435, 4to.

The quotations from Bichat, "*L'Anatomie n'est pas telle qu'on l'enseigne dans les écoles*," which the author adopts in the title page of the work, suggests its *raison d'être*. In the present instance, anatomy is presented to us from a special standpoint—Regional Anatomy, or "the anatomy of the different regions of the body individually considered, in the relations of the parts to one another, as they are naturally found," which the author regards as the most direct method of studying the subjects. The author correctly admits that there can not be any means of illustration equal to the real thing in teaching, and the best substitute is that which aims at producing the most realistic impressions. The special mission of this work is to offer this substitute "by reproducing nature as accurately as possible by means of plates which have been expressly prepared to illustrate and verify the descriptions, and are as faithful representations of actual dissections as photography could make them." There are in this first volume fifty-three plates, embracing about one hundred and four figures, and covering the regions of the head, neck, thorax and upper extremities, with special reference to their medical and surgical applications. The plates are fac-simile lithographic reproductions of the photographs of the author's dissections, and in this respect constitute an unique and very interesting addition to pictorial anatomical literature.

The work is an ambitious effort in a new and modern direction. It has been conceived in the right spirit and conscientiously carried out. The author has been very painstaking, and the number and excellence of his dissections are a monument to his industry, enthusiasm and skill. We can certainly state that in many, and even the majority, of the *larger* plates, the natural appearances and effects have been strikingly reproduced. In the smaller figures, representing complex regions, better work could have been done. Throughout the series it is noticeable that the author has been compelled to resort to artificial devices, such as retouching the outlines and contours of vessels, nerves and organs, in order to bring them into relief, and thus save them from the indefiniteness and general mistiness of the photographs. Plates 38, 39 and 40, which show the posterior mediastinum and thorax after removal of the posterior chest wall, are, if correct in some respects, very inartistic, blurred and confusing, and could hardly be attributed

to the same process that has furnished plates 15, 16, 17, 18, 19, 20 and 21, which are positively brilliant successes.

Without attempting to criticise in detail, we would call attention to the glaring defects of fig. 2, plate 10; plate 12; and the inadequacy of plate 7, figs. 1, 2; and plate 8, figs. 1, 2, to instruct in that most important topic, cerebral localization.

There is no doubt, however, that notwithstanding many imperfections we can safely affirm the author's success in realizing his intention, but this admission does not satisfy the question as to whether the photographs of dissections are superior for didactic purposes to the more artificial and diagrammatic representations of the classical texts. In comparing the illustrations of work with the types of the higher and most artistic counterfeits of anatomical regions, such as exhibited by the monumental masterpieces of Jacob and Bourguery, or in the less ponderous works of Leveille, Tillaux, or the still incomplete Merkel (*Topographische Anatomie*), the reviewer must acknowledge his decided preference from all standpoints, but especially from that of the teacher, for the latter. Photographic anatomy, like photographic histology, has its very useful applications, but these are, as a rule, restricted to studies of *ensemble* or of the whole, but are exceedingly unsatisfactory in clearing up the details—details which constitute the very essence of that most analytic study—*anatomy*.

The author himself fully appreciates these difficulties when he says "that it should be borne in mind that no true picture of the actual subjects will have the distinct demarcation and clearness of a diagram any more than the representation of a natural landscape indicates mountains, rivers, boundary lines, with the exactness of a map. Diagrams will, therefore, always be useful to the student in showing him what he ought to see, but such illustrations as are here attempted should be valuable in enabling him to recognize things as they actually are." We could only go a step further, and borrowing the author's simile, would insist that in the study of human topography the photograph of the landscape, while very interesting, is not as essential to the professional surveyor as the analytical and detailed study of the ground, such as is furnished by the systematic anatomists. The synthetic presentation of the subjects should be subsequent and complementary to its analytical study, and, for this reason, we believe that this work can only be of real service to those who are already initiated and familiar with anatomical work.

In regard to the text we can only say that every paragraph reveals the hand of the experienced teacher. It is a model of

synoptical lucidity; nothing superfluous; everything that is essential is here presented in the briefest and most acceptable form. The section on cranio-cerebral topography reveals an intuitive appreciation of all that which is broadly called "practical" and which is the outcome of a keen and cultivated appreciation of the more urgent needs of the clinician.

We certainly congratulate the author on the successful completion of this first volume of his *Regional Anatomy*. Work of this kind deserves encouragement, not only because of its unique character, but also because it displays an amount of patient, original and conscientious effort in the pursuit of a meritorious idea, which is remarkably uncommon among the authors of this plethoric era of cheap, easy and parasitic authorship.

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R. M.

*A Text Book of Physiology.* By M. Foster, M. A., M. D., LL. D., F. R. S., Professor of Physiology in the University of Cambridge and Fellow of Trinity College, Cambridge. Fourth American, from the Fifth English Edition, thoroughly revised, with notes, additions and two hundred and eighty-two illustrations. Philadelphia: Lea Brothers & Co., 1891.

The deep learning and thorough comprehension of his subject which is displayed by the author of this work commends it to any one who seeks to become thoroughly posted on physiology. The work, issued in England in instalments, is complete in the American edition before us—that is to say, it is as complete as the author intended it to be, for he has intentionally omitted giving the physiological anatomy of many of the organs, and the illustrations that usually accompany descriptions of them.

Although it is fair to presuppose in the practitioner of medicine a general acquaintance with topographical anatomy, it is also fair to presuppose that he may be somewhat rusty, and in a condition to be reminded of subjects half remembered and half forgotten. The American editor does not apologize for these omissions, but he evidently recognizes them, for in some places there has been a feeble attempt at supplying them. The chapter treating on "The Brain" is quite up to date, and is, perhaps, the best we have seen. In a book of 1060 pages, 156 are given to the study of the brain alone.

The philosophic vein pervading the work makes it very agreeable reading, but the peculiar arrangement of the subject makes it one more adapted to graduates than students of medicine striving for a diploma.

H. W. B.



*A text book of Practical Therapeutics, with especial reference to the application of remedial measures to disease, and their employment upon a rational basis.* By Hobart Amory Hare, M. D., B. Sc. Second edition, enlarged and thoroughly revised. 1891. (Lea Bros. & Co., Philadelphia; Armand Hawkins, 194 Canal street, New Orleans.) Cloth, \$3.75; sheep, \$4.75.

The fact that the first edition of this work was exhausted within six months after its publication, and that it has been adopted as a text book in several of the leading schools, is ample proof that the profession have approved the author's work. The present edition is well up to date. Several new drugs have been added, and the author has an article on the method of employing the rest cure, and the use of suspension in the treatment of locomotor ataxia. Part I is devoted to general therapeutic considerations. In part II drugs are discussed, including from what they are derived, their physiological actions and the therapeutical indications for their use.

In part III is an excellent article on foods for the sick, and in part IV diseases and the drugs indicated in them are discussed. The drugs are discussed alphabetically in section II. While this arrangement has many advantages we think that students could remember them much better if they were classed according to their physiological actions. On the whole, we can recommend this book as one of the best on this subject, and congratulate Dr. Hare on the success of it.

W. E. P.

*A Practical Treatise on the Diseases of Women.* By T. Gailliard Thomas, M. D., LL. D., Professor Emeritus of Diseases of Women in the College of Physicians and Surgeons, New York; Consulting Surgeon to the New York State Woman's Hospital; Honorary Fellow of the Obstetrical Society of London; Corresponding Fellow of the Obstetrical Society of Berlin, etc. Sixth Edition: Enlarged and thoroughly revised by Paul F. Mundé, M. D., Professor of Gynecology at the New York Polyclinic and at Dartmouth College; Gynecologist to Mount Sinai Hospital; Consulting Gynecologist to St. Elizabeth and the Italian Hospital, etc. Containing 347 engravings on wood. Philadelphia: Lea Bros. & Co., 1891.

It is now ten years since the classical work of Gailliard Thomas appeared in its fifth edition, and now the many progressive changes noted in gynecology during this time have been added

to the book by the pen of a surgeon amply qualified to perform the work which Dr. Thomas' extensive practice has prevented him from doing. It is announced that Dr. Mundé's revision meets with the approval of Dr. Thomas, and where these two authorities differ in the work the reader is made aware of it by bracketed initials appended to the opinions given.

Large portions of the fifth edition have been left out to make way for the new matter of the sixth; the latter containing for the first time chapters on *Electricity*, *Hermaphroditism*, *Diseases of the Urethra and Bladder*, and the *Diseases of the Female Breast*.

An interesting addition appearing in the last edition is the following paragraph:

"Recently, a supposed infallible diagnostic sign of gonorrhœal infection has been discovered by Neisser, who under the microscope detected a peculiar bacterium, which he called the gonococcus, and which he claims exists only in this disease. There may fairly be said to be still some doubt on this subject. A positive differentiation between a severe case of acute or subacute simple vaginitis, and one caused by gonorrhœal infection can, in our opinion, seldom if ever be made."

In the chapter on Laparotomy Dr. Mundé says: "Before concluding this chapter I wish to state my conviction that the pathological influence of fibroid tumors as a whole is over-estimated by the profession at large, and that many women are made unhappy by the knowledge, incautiously imparted to them by their medical attendant, that they have a tumor of this kind."

He has observed 123 cases, which are 4.14 per cent. of all the gynecological cases seen by him between 1886 and 1889, and only sixty-two of those cases required treatment of any kind whatsoever. "The remaining sixty-one—that is, about one-half—afforded their owners so little inconvenience, or gave so little prospect of becoming troublesome, that not even a medical treatment was thought necessary."

In the fifth edition several pages are devoted to the subject of extirpation of the uterus, although Thomas does not advocate it, declaring the operation of Professor Frend as *ad hoc sub judice*.

The sixth edition disposes of hysterectomy as being "practically abandoned in favor of the very much safer and equally efficient vaginal method." The vaginal method is fully described.

Finally, we would congratulate Dr. Mundé on his successful efforts in improving a book which was previously so deserving of praise and study.

H. W. B.

*The Medical News Visiting List for 1892.*

Messrs. Lea Bros. & Co. have issued their Visiting List for 1892. It is unnecessary to dilate upon the necessity of such an aid to the practitioner. Visiting lists have improved with time, and each edition discloses some improvement upon its predecessors. *The Medical News Visiting List* not only contains pages for recording work done, but it also contains tables of weights, doses, etc.; notes on the examination of urine; what to do in emergencies, etc. A therapeutic table, compiled by Dr. H. A. Hare from his *Text-Book on Practical Therapeutics*, fills ten pages, and furnishes the busy doctor with a ready reference index when he needs a little information in a hurry.

A. McS.

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## State News and Medical Items.

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Communications from Physicians of Louisiana are solicited for this Department. News of personal interest is especially desired.]

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### CHARITY HOSPITAL.

The board of administrators of the Charity Hospital met November 2d. with Dr. C. J. Bickham in the chair, Secretary Marks and these gentlemen present: Messrs. McManus, Sentell, Joubert, Keller and Geo. Seeman.

The business was opened by the secretary reading the appointment of Mr. Leon Joubert to fill the vacancy occasioned by the death of Mr. Devereux.

House Surgeon Miles reported that he had returned from his vacation since the last meeting of the board. While in New York he bought a number of surgical instruments to be used in the operating rooms. The doctor said, that before he left, he was in doubts if the rooms of the new clinic building would be large enough for the purpose. Since he has returned and inspected them, all doubt has been dispelled, and he has begun preparations for furnishing them. He thought that both buildings should be opened on January 1, so that the outdoor statistics could be satisfactorily completed.



The following financial report was then read:

From ordinary sources .....	\$14,139 36
Cash balance October 1, 1891.....	42,118 70
	<hr/>
	\$56,258 06
DISBURSEMENTS.	
On account of improvements.....	\$1,331 27
Ordinary expenses.....	5,698 99
	<hr/>
	\$7,030 26
Cash balance October 31, 1891.....	49,227 80

The finance committee reported that an account had been opened with the Canal Bank. Secretary Marks then read the following reports of the clerk of the hospital:

Number of patients remaining in hospital October 1, 1891, 591; number of patients admitted, 639, as follows: Foreigners 276, United States 427—males 528, under 10 years 11, total 539; females 143, under 10 years 11, total 154. Number of patients discharged 564—males 438, under 10 years 5, total 443; females 112, under 10 years 9, total 121. Number of patients died 91—males 61, under 10 years 3, total 64; females 25, under 10 years 2, total 27. Number of patients remaining in hospital November 1, 599—males 400, females 199. Daily average of patients during the month, 590.

Ambulance Report.—Total calls 130, average time 34 minutes, surgical calls 66, medical 13, dressed 29, conveyed home 3, obstetrical 2, died 5, false 2, not needed 8, transfer calls 2.

Architect Carter announced that the woman's and children's outdoor clinic was completed and ready to turn over to the board, and that the men and boys' clinic building had progressed so far that the roof was about to be put on.

Five thousand dollars were transferred from the general fund to the building fund. After discussing some minor affairs the meeting then adjourned.—*Picayune*.

#### THE EYE, EAR, NOSE AND THROAT HOSPITAL.

The usual monthly meeting of the trustees of the Eye, Ear, Nose and Throat Hospital was held on November 4, with the following gentlemen in attendance:

President W. B. Schmidt, Secretary Jos. A. Hincks, Messrs. James T. Hayden, Jules Aldige, Chas. K. Hall and Dr. A. W. de Roaldes.

Secretary Hincks' report of patients treated during the month was in substance as follows:

Refused admittance, 13; admissions 332, as follows: eye

department, 161; ear, nose and throat, 171; consultations, eye department, 1513; special cases, 28; ear, nose and throat department, 1392; total, 2933; operations in eye department, 28; in ear, nose and throat department, 27; total, 55.

The report of Dr. A. McShane, the pathologist, was read. It represents the work done by his department since its inauguration: Number of specimens examined, sputum, 71; urine, 63; tumors, 4. Number of specimens mounted for examination, 114.

Dr. de Roaldes reported that he was happy to have returned from his vacation abroad and resumed his duties. Owing to sickness of more than two months' duration, during which he had several operations performed, he was not able to devote as much attention to the interests of the institution as on former occasions. However, he visited most of the English and French institutions of note devoted to the treatment of ear, eye, nose and throat diseases, and purchased a number of medical works and instruments to be used in the hospital here.

The doctor recommended that in the future reports of the secretary, the number of the patients from the city and country be classified, so that if application ever be made to the State or city for assistance the hospital may have statistics upon which to base its claims. The recommendation was adopted.

The tardiness of some of the visiting physicians was criticised, and it was decided to return to the former method of keeping a daily record of the time at which the visiting staff reported. This will diminish some of the vexatious delays to which patients have been subjected.

Again the question of securing a permanent home was discussed. There is a lease of eleven months on the present building, but the trustees are looking around for a more roomy building. A committee was appointed to examine and consider property that may be offered for the purpose.

Dr. O. S. Pothier tendered his resignation as ear, nose and throat clinical assistant, and was appointed assistant pathologist. Dr. L. Hanneman was appointed to the vacancy caused by the resignation of Dr. Pothier.

A letter was read from the manager of the Ovide Musin Concert Company, stating that the company would be here during the spring, and proposing that arrangements be made for giving the hospital a benefit.

Up to the present time there have been no life members of the institution, notwithstanding a number of applications have been received from persons to become such. It had been the intention of the trustees to discuss the question at the next annual meeting this winter, but in consideration of

another application, the question was brought up last night, and \$500 decided as the fee. In explanation of this sum the trustees say, as there are not so many millionaires in New Orleans as in New York and other large cities, it would be unjust to make the life membership fee as costly as in Northern charitable institutions. To all persons who can afford it, however, the trustees extend an invitation to contribute to the permanent building fund.

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DR. J. W. DAY has moved to Homer, La., from Dykesville.

DR. GEO. W. LEWIS has returned to the city from the North.

DR. AND MRS. T. G. RICHARDSON have returned from a visit North.

DR. A. MAGUIRE has returned to his home in Jeanerette, after a visit to Canada.

DR. R. T. WORLEY lost two daughters by the burning of the steamboat *Oliver Bierne*.

MARRIED.—On November 2, 1891, Dr. Harry Hayward to Miss Lila More, both of New Orleans. Dr. and Mrs. Hayward made a bridal trip to Washington, D. C., and have returned and are at home to their friends at 297 Coliseum street, on Fridays.

DR. MOORE, lately of Hico, is now a resident of Ruston. He has bought a home, and will practice there.

DR. WM. S. HARVEY, of Chicago, was married to Miss Alice E. Flash, of this city, on November 25, in New Orleans.

DIED.—At Vanceville, La., on Thursday evening, November 12, Susie, infant daughter of Dr. G. A. Wise, aged ten months.

DR. JACKSON, of Montgomery, La., and his daughter, Miss Mildred, late pupil of the Conservatory of Music, are in the city for a few days.

MARRIED.—Dr. W. J. Scaife, of Homer, La., and Miss Blandel Griffin, of Ruston, were married last Tuesday evening at the home of the bride in Ruston.



DR. RICHARD H. WESTERFIELD, age seventy-one, died at Buras, parish of Plaquemine, La., October 29, of malarial fever. He had resided there thirty-six years.

A \$6000 FIRE occurred in Mansfield on November 17. The offices of Dr. Sutherlin were destroyed. We extend our sympathy to the doctor.

MARRIED.—At the residence of the bride's father, Mr. S. S. Pearce, at Evergreen La., on Wednesday evening, November 14, 1891, Miss Jennie Pearce to Dr. Herbert Kilpatrick, of Mooreland, La.

DR. J. A. WATSON, a representative of the American Public Health Association, and Dr. Edward French, assistant superintendent of the New Hampshire Insane Asylum, were in New Orleans recently, en route to Mexico and South America. Our quarantine system was thoroughly inspected by the gentlemen during their stay.

The little daughter of Dr. A. G. Bowman, of Monroe, La., was burned to death on October 19. Her clothing ignited while standing in front of the fire. Mrs. Bowman was badly burned in attempting to rescue her daughter from the flames.

THE OUACHITA DRUG COMPANY is a new and important enterprise for Monroe. The capital stock is fixed at \$100,000, and \$30,000 has already been paid in. Dr. M. A. McHenry, of Arkansas, is president of the company; Dr. T. O. Brewer, vice president; E. F. Buckingham, secretary and treasurer; and Dr. T. O. Brewer, R. B. Blanks, D. B. Pugh, Dr. M. A. McHenry and Dr. R. Layton, directors.

DR. FELIX FORMENTO, who represented the Board of Health of this State at the meeting of the American Public Health Association, held last week at Kansas City, Mo., was elected president of that body. Dr. Formento, upon graduation, served with distinction in the medical corps of the Franco-Italian army in the campaign against Austria, and soon after his return to this country, at the breaking out of the war of secession, was appointed a surgeon in the Confederate service and placed in charge of the Louisiana Hospital at Richmond, Va. At the close of the war he returned to this his native city and resumed the practice of his profession, taking the high rank

that his distinguished services and abilities so justly entitled him to hold The Doctor has won him the warm friendship and esteem of a wide circle of his fellow-citizens, who will be delighted to hear oft his notable recognition of his merit. Among these are his comrades of the Association of the Army of Northern Virginia, Camp No. 1, United Confederate Veterans, of which he has been for years a surgeon and member.

MARRIED.—SURGHNOR-FONTAINE.—At Vicksburg, Miss., Wednesday, November 18, 1891, Dr. Graham Surghnor, of this city, and Miss May Fontaine, of Vicksburg, Miss.

DR. F. B. SHUFORD died at Holly Springs, Miss., at 5:30, November 25. He leaves a wife and four children, two sons and two daughters. He was an old resident of that city, having located there in 1847, and continued his practice until 1861, when he retired to engage in banking, and held the position in the Holly Springs Bank as cashier until 1881, when he retired on account of his health.

A nice point of law has lately been debated before a French court. The question was whether an operation on a dead body by an unqualified person came within the meaning of the enactment forbidding the illegal practice of medicine. It appears that a pregnant woman had just died, the cause of death not being stated. The curé of the village, who had been with her in her last moments, induced a neighbor who was in the room to perform cæsarean section on the corpse with a view of saving the child. The operation was successful, but the operator was brought before the magistrate and fined 15 francs for having been guilty of illegal practice of medicine.—*British Medical Journal*.

A CHINESE RECIPE FOR LONG LIFE.—A sample of a "Fairy Recipe for Long Life," cited by a writer in the *Cornhill*, is heralded by the statement that the nostrum "has come down to us from a physician of the Ming Dynasty." A certain official was journeying in the hill country when he saw a woman passing southward over the mountain as if flying. In her hand she held a stick, and she was pursuing an old fellow of a hundred years. The mandarin asked the woman, saying

“Why do you beat that old man?” “He is my grandson,” she answered, “for I am 500 years old and he is 111: he will not purify himself or take his medicine, and so I am beating him.” The mandarin alighted from his horse and knelt down and did obeisance to her, saying: “Give me, I pray you, this drug, that I may hand it down to posterity for the salvation of mankind.” Hence it got its name. Take it, says the Chinese advertisement, for five days, and the body will feel light; take it for ten days, and your spirits will become brisk; for twenty days, and the voice will be strong and clear, and the hands and feet supple; for one year, and white hairs become black again, and you move as though flying. Take it constantly and all troubles will vanish: and you will pass a long life without growing old. All this for three and sixpence the bottle.—*Pacific Record*.

PERIODS OF GESTATION are the same in the horse and ass, 10 months each; camel, 12 months; elephant, 2 years; lion, 5 months; buffalo, 12 months; cow, 9 months; sheep, 5 months; reindeer, 8 months; monkey, 7 months; bear, 6 months; sow, 4 months; dog, 9 weeks; cat, 8 weeks; rabbit, 4 weeks; guinea pig, 4 weeks; wolf, 90 to 95 days. Goose sets 30 days; swans, 42 days; hens, 21 days; ducks, 28 days; pea hens and turkeys, 28 days; canaries, 14 days; pigeons, 14 days; parrots, 40 days.—*Western Medical Journal*.

A correspondent of the *Washington Star*, who has been studying the subject of getting rid of fleas, gives this as the result of his investigations: If those who are troubled with this insect will place the common adhesive fly-paper on the floors of the rooms infested, with a small piece of fresh meat in the center of each sheet, they will find that the fleas will jump toward the meat and adhere to the paper. I completely rid a badly infested house in two nights by this means.

A NEW SOURCE OF QUININE.—It is announced as one of the most important discoveries of the present year that Messrs. Grimaux and Arnaud, of Paris, have succeeded in producing quinine from a Brazilian syrup. The result is quinine, absolutely identical with the substance that has become so familiar to us all, and so indispensable to medicine.



ARISTOL IN POISONING.—In a case of poisoning of the hands from *Rhus toxicodendron*—poison oak—recently under my care, which had reached the vesicular stage, and was attended with much swelling and burning, the happiest results followed the free dusting of the powder of aristol on the affected parts. The change was almost magical, so sudden and so prompt was the relief afforded. Might not this powder, applied in the early stage of the disease, do much toward preventing the ulceration and pitting of variola?—*Med. News*.

The natives of the New Hebrides smear the points of their arrows with a swamp earth, the poisonous agent in which, according to Dr. Ledantec, is the septic vibrio of the tetanus bacillus.—*Medical Drug Reporter*.

The Superintendent of the Census makes public a bulletin in which are given statistics upon the subject of asylums for the insane in the United States. The bulletin shows that the total number of insane persons treated in both public and private institutions during the year 1889 was 97,535, while during the year 1881 there were 56,205 treated, showing an increase in the nine years of 41,330 or 73.53 per cent.

As a curiosity of diagnostication, the Chinese method of determining the state of the fœtus is worthy of attention. "When the face of the mother is red and the tongue green, the fœtus is dead. If the face is green and the tongue red, the infant is living, but the mother will die. When the face and the tongue of the mother are both green, the child and mother will both die at the same time." This is rather puzzling to obstetricians of the white race: perhaps the chromatogenetic effect of pregnancy on the skin of the Chinese woman is different from that of her white sisters.—*Exchange*.

Brazil has a law for the medical examination of persons about to marry to determine their fitness. It is a sanitary measure that is found to be necessary to stop the transmission of scrofula, which at one time threatened to destroy the strength of the people.

PATIENT (at Christian scientist's office)—Is the healer in?

ATTENDANT—Yes, sir; but she is sick to-day and can't do any business.

A hospital for women has been opened at Sitka, Alaska, by Dr. Clarence Thwing. It is the first in that country.

The sale of tuberculin is forbidden in Munich.

Indiana has an infant prodigy, a boy six years of age, who gives lectures on anatomy. Our supposition is that he is not yet weaned and is still pulling on his subject.

THE OTHER MAN LAID ON.—Minister—"Who is the deceased?"

Attendant—"Oh, he was a faith healer. He used to go about the country laying on of hands, but one day he laid hands on the wrong man; there was a reaction, and the result was fatal to the healer."—*Pharmaceutical Era*.

"What did the doctor pronounce your ailment?" inquired she with a tremor of anxiety in her tone as she came into her husband's sick room.

"He pronounced it as if it was spelled bronkeetus," exclaimed the indignant Bostonian, straightening himself up in bed, "and I requested him at once to make out his bill and go."—*Chicago Tribune*.

DOCTOR—I believe you have some sort of poison in your system.

PATIENT—Shouldn't wonder. What was that last stuff you gave me?—*New York Weekly*.

A LAW FOR THE PREVENTION OF BLINDNESS.—Following the example of the State of New York, where a similar law was passed in 1890, the State of Maine has passed the following law, which was approved by the Governor on March 28: "Section 1. Should one or both eyes of an infant become reddened or inflamed at any time within four weeks after its birth, it shall be the duty of the midwife, nurse or person having charge of said infant, to report the condition of the eyes at once to some legally qualified practitioner of medicine of the city, town or district in which the parents of the child reside. Sec. 2. Any failure to comply with the provisions of this act shall be punishable by a fine not to exceed \$100, or imprisonment not to exceed six months, or both. Sec. 3. This act shall take effect on the first day of June, eighteen hundred and ninety-one."

"Died of gravel" was the verdict of a coroner's jury in Oil City, in case of laborers buried under an embankment.

MEDICAL EXAMINATION.—On Tuesday, September 22, there was an examination at the City Hospital, of Natchez, Miss., of the five resident students, who have been receiving instructions for some time under the efficient surgeon, Dr. B. D. Watkins. It was a written examination, the questions being prepared by Drs. A. J. Hall and N. L. Guice. The examination was held for the purpose of awarding a set of valuable medical books, given as a prize by Dr. Watkins.

The following is said to have happened in a certain Bible class at a very noted female college in Virginia:

Lady Teacher—Miss Annie, what do you understand by the word "circumcision" used in to-day's lesson?

Miss A.—It is taking the scalp off a male baby when eight days old.—*So. Medical Journal*.

The oldest medical work—an Egyptian papyrus dating from 1500 years or more before Christ, and containing prescriptions then old—has been translated by Ebers, the German novelist.

Venereal diseases are said to be almost unknown among the laboring men of Paris. Out of 3240 men in the prime of life, Dr. Fiaux found but five suffering from gonorrhœa and chancroid, and not one from syphilis. These men were applicants for work on a railroad.

Nothing so quickly restores tone to exhausted nerves and strength to a weary body as a bath containing an ounce of aqua ammonia to each pail of water. It makes the flesh firm and smooth as marble, and renders the body pure and free from odor.—*Annals of Hygiene*.

"Aunt Sallie, what's the matter with Aby?"

"The doctors say he got two-buckles on his lungs. Dat's what went with my two shoe buckles I los' last month. Cain't leave nuffin' around de house now on account dat boy."

THE NUMBER OF TUBERCLE BACILLI IN PHTHISICAL SPUTUM.—Dr. E. H. F. Nuttall, of John Hopkins University, has shown that phthysical patients expectorate from 250,000 to 4,000,000,000 bacilli in twenty-four hours. Taking the aver-



age of, we will say, 100,000,000 per day, the patient would expectorate 365,000,000,000 bacilli a year, and if he lives three years, the total number of microorganisms expectorated during his illness would be 1,095,000,000,000. Or multiply the years' annual out-put of 365,000,000,000 by 75,000, the number of cases of phthisis in this country, and we are confronted with the sanitary problem of destroying 75,000 times 365,000,000,000 microbes every year. These are rather discouraging figures, but it may be supposed that the vast majority of tubercle bacilli in the sputum die as the result of intercurrent disease or a pitiless environment.—*Medical Record*.—*Medical Age*.

In Corea, physicians are only allowed to examine the patient in the following manner: A thread is tied around the patient's wrist and passed out by a hole in the wall to the doctor outside, who by inspecting the thread, is supposed to arrive at a diagnosis. Corean doctors are evidently gifted with what may be termed the "*tactus eruditus*."

DR. CONCEPCION ALEXANDRE has recently been appointed upon the staff of the Hospital de la Princesa in Madrid. This is said to be the first appointment of a woman to any official position in Spain.—*Med. Record*.

FEMALE PHARMACISTS IN RUSSIA.—The State Council of Russia has decided to admit females to the study of pharmacy at all Russian universities; they must not be less than 16, nor more than 40 years of age, and after three years' study may present themselves for the final examinations, the same as the male candidates.

DEEPLY CONCERNED.—"Your uncle, sir," said the physician who had been hastily called in, "is threatened with softened of the brain."

"Any symptoms of that kind about his heart?" inquired the poor relation anxiously.

The committee of the British Medical Association on legislation for the inebriate, has reported in favor of endowing proper authorities with power to compel inebriates to be placed in retreats where they will be treated by physicians employing the most approved methods.

Citizen—"Did the amputation do the man any good?"

Doctor—"Oh, no! but it was a beautiful operation."—*Puck*.

A QUAIN EPITAPH.—The following quaint epitaph on husband and wife—the husband having died first—is to be seen in one of the Parisian cemeteries: "I am anxiously awaiting you.—A. D. 1827." "Here I am.—A. D. 1867." The good lady had taken her time about it.—*Ex.*

MEDICAL BUREAU OF THE WORLD'S COLUMBIAN EXPOSITION.—The Bureau was organized June 1, 1891. The staff consists of John E. Owens, M. D., Medical Director; W. H. Allport, N. R. Yeager, S. C. Plummer, Assistant Surgeons. The Bureau took charge of the medical, surgical and sanitary inspection work on the grounds July 1, 1891, and is now in active operation. The present Bureau, operating during the construction period, will be the nucleus of the medical service of the World's Fair. It is the intention of the Medical Director to make the records of the Bureau as complete as possible from a statistical and historical standpoint, and to furnish at the close of the service a report, which will be valuable in the organization of the medical bureaus of future exhibitions.—*Univ. Med. Mag.*

THE TREATMENT OF STAMMERING.—According to returns founded upon German statistics collected during the last sixteen years, the average number of stammering school children in Berlin and elsewhere amounts to about  $1\frac{1}{4}$  per cent. of the total number in attendance. The causes of this defect, and the method of dealing with it, are discussed by Mr. E. J. Seltman, in *Phisique*. He observes it is needless to seek for etiological conditions in the organs of speech themselves, or even in the nerves associated with them. The stammerer, if his mind is at ease, does not stammer. It is in the presence of circumstances, varying in different cases, which to him suggest some imaginary difficulty, that his impediment becomes apparent. Concurrently with this comes a feeling that he must speak. Intelligence and will together urge him to do so: the purpose is met by his conscious unreadiness, and the consequence is the marred result with

which he himself and his companions are painfully familiar. His impediment, therefore, is imaginary. The remedies appropriate to his condition, if somewhat slow in operation, are not far to seek. They consist essentially in a change in a disentanglement of his perverted mental energies. All mental shock is to be strictly excluded. The habit cannot be cured by order. He must be approached with tact, and habitually addressed in a quiet, slow and deliberative manner. His imitative instinct will copy the method, and fluency will usually succeed the faculty of correct utterance thus engendered. When we reflect upon the frequently high intelligence of stammering children, the drawback imposed upon their education by this unfortunate habit, and its equally hurtful influence upon their usefulness as adults, we cannot too strongly impress the necessity of its early and methodical treatment. A course of three months will often suffice to attain the desired results.—*Lancet*.—*Medical Bulletin*.

#### A MINISTERING ANGEL.

O woman, in our hours of ease,  
Uncertain, coy and hard to please;  
When pain and anguish wring the brow,  
Then none so cheaply pleased as thou!  
We've only to submit to take  
Hot rhubarb tea and anti-ache,  
And gizzard oil and ipecac,  
And porous plasters on the back,  
A flax-seed poultice, catnip tea,  
And Quackem's new discovery.  
Hot-water bags and sweats beside,  
And camphor nasally applied,  
And castor oil and vaselin,  
And coals with feathers burnt between,  
And soothing syrup, paregoric,  
Cold-water cloths and drinks caloric,  
And all the housewife's category.  
'Tis then we see her in her glory,  
Needing to make her bliss complete,  
But mustard plasters on our feet.

—*Harper's Bazar*.



## MORTUARY REPORT OF NEW ORLEANS.

FOR OCTOBER, 1891.

CAUSE.	White	Colored	Male	Female	Adults	Children	Total
Fever, Yellow .....							
“ Malarial (unclassified)....	11	6	12	5	11	6	17
“ Intermittent .....	1		1		1		1
“ Remittent .....	6	1	7		7		7
“ Congestive .....		1	1		1		1
“ Typho-Malarial....	6	2	4	4	6	2	8
“ Typhoid or Enteric.....	2		2		2		2
“ Puerperal .....							
Scarlatina .....							
Small-pox .....							
Measles .....							
Diphtheria .....	16	1	6	11		17	17
Whooping Cough .....							
Meningitis .....	8	1		9	3	6	9
Pneumonia .....	6	7	10	3	8	5	13
Bronchitis .....	7	2	5	4	6	3	9
Consumption .....	40	40	28	52	77	3	80
Cancer .....	13	7	6	14	20		20
Congestion of Brain.....	3	2	2	3	2	3	5
Bright's Disease (Nephritis) ...	13	9	11	11	20	2	22
Diarrhœa (Enteritis) .....	7	7	11	3	11	3	14
Cholera Infantum .....	3	2	3	2		5	5
Dysentery .....	7	4	6	5	11		11
Debility, General .....	2	1		3	3		3
“ Senile .....	14	12	11	15	26		26
“ Infantile .....	6	6	8	4		12	12
All other causes .....	153	79	129	103	153	79	232
TOTAL .....	324	190	263	251	368	146	514

Still-born Children—White, 20; colored, 19; total, 39.

Population of City—White, 184,500; colored, 69,500; total, 254,000.

Death Rate per 1000 per annum for City—White, 21.07; colored, 32.81.  
total, 24.25.F. W. PARHAM, M. D.,  
Chief Sanitary Inspector.

## METEOROLOGICAL SUMMARY—OCTOBER.

STATION—NEW ORLEANS.

Date.....	TEMPERATURE.			Precipn. in inches and hundredths..	SUMMARY.
	Mean	Max.	Min.		
1	80	85	74	0	Mean barometer, 30.153.
2	78	83	72	.22	Highest barometer, 30.36, 29th.
3	78	84	73	1.58	Lowest barometer, 29.58, 4th.
4	78	85	70	.6	Mean temperature, 67.8.
5	76	81	72	T	Highest temp., 85, 1st; lowest, 50, 8th.
6	70	77	64	0	Greatest daily range of temperature, 23, 24th.
7	71	78	64	0	Least daily range of temperature, 9, 5th.
8	60	70	50	0	MEAN TEMPERATURE FOR THIS MONTH IN—
9	64	71	58	0	
10	62	70	54	0	1871.....70.7    1876.....67.4    1881.....75.2    1886.....69.5
11	65	73	57	0	1872.....68.2    1877.....69.9    1882.....73.3    1887.....68.1
12	66	75	57	0	1873.....67.9    1878.....70.9    1883.....75.4    1888.....68.0
13	66	74	58	0	1874.....70.2    1879.....72.2    1884.....74.4    1889.....70.4
14	68	78	59	0	1875.....66.9    1880.....67.9    1885.....65.7    1890.....69.0
15	69	78	60	0	1891.....67.5
16	68	77	58	0	Total deficiency in temp'ture during month, 90.
17	68	77	58	0	Total deficiency in temp'ture since Jan. 1, 194.
18	70	80	59	0	Prevailing direction of wind, N. E.
19	62	68	56	0	Total movement of wind, 6101 miles.
20	60	69	52	0	Extreme velocity of wind, direction, and date,
21	65	76	54	0	25 miles, from North, 8th.
22	66	76	57	0	Total precipitation, 2.38 inches.
23	61	71	51	0	Number of days on which .01 inch or more of
24	66	78	55	0	precipitation fell, 3.
25	68	78	59	0	TOTAL PRECIPITATION (IN INCHES AND HUNDREDTHS)
26	70	79	60	0	
27	70	80	60	0	FOR THIS MONTH IN—
28	58	65	51	0	
29	62	72	52	0	1871.....9.09    1876.....0.24    1881.....4.84    1886.....0.22
30	67	75	59	T	1872.....3.18    1877.....9.15    1882.....2.16    1887.....4.79
31	70	78	63	0	1873.....1.39    1878.....5.07    1883.....3.43    1888.....7.36
					1874.....0.00    1879.....1.36    1884.....5.00    1889.....0.20
					1875.....2.09    1880.....1.88    1885.....0.56    1890.....5.24
					1891.....2.33
					Total deficiency in precip'n during month, 1.04.
					Total deficiency in precip'n since Jan. 1, 22.44.
					Number of clear days, 24; partly cloudy days,
					6; cloudy days, 1.
					Dates of Frost, .....
					Mean maximum temperature, 76.2.
					Mean minimum temperature, 59.5.

NOTE.—Barometer reduced to sea level. The T indicates trace of precipitation.

G. E. HUNT, *Local Forecast Official.*

# Most Powerful Purgative Water Known

$\frac{1}{4}$  THE QUANTITY REQUIRED BY OTHERS

ABSOLUTELY HARMLESS AS IT CONTAINS  
ALMOST EXCLUSIVELY SULPHATE OF SODA.

NO REPULSIVE SMELL NOR BITTER TASTE

## VILLACABRAS

NOT FOLLOWED BY CONSTIPATION

CAN BE TAKEN INDEFINITELY AS A LAXATIVE  
WITHOUT ILL EFFECTS.

INVALUABLE IN LONG STANDING CASES OF STUBBORN  
CONSTIPATION.  
INFANTS AND ADULTS.

**COURD & TOURNADE, Sole Agents**

25 & 27 S. WILLIAM STREET, N. Y.

NO  
CRIPES

NO  
PAIN

## A Solution of Pepsin

Of high digestive power in small bulk, renders the administration of Pepsin in the liquid form entirely satisfactory both to physician and patient. Combines elegance of preparation with prompt and certain action. Armour's Glycerole Pepsin is the ideal liquid pepsin. 10 minims equal 1 grain 2500 test pepsin. Samples on application.

Armour & Company  
Chicago



# SYR. HYPOPHOS. CO., FELLOWS.

Contains the Essential Elements of the Animal Organization--Potash and Lime;

The Oxidising Agents--Iron and Manganese;

The Tonics--Quinine and Strychnine;

And the Vitalizing Constituent--Phosphorus; the whole combined in the form of a Syrup with a **Slightly Alkaline Reaction.**

It Differs in its Effects from all Analogous Preparations: and it possesses the important properties of being pleasant to the taste, easily borne by the stomach, and harmless under prolonged use.

It has Gained a Wide Reputation, particularly in the treatment of Pulmonary Tuberculosis, Chronic Bronchitis, and other affections of the respiratory organs. It has also been employed with much success in various nervous and debilitating diseases.

Its Curative Power is largely attributable to its stimulant, tonic, and nutritive properties, by means of which the energy of the system is recruited.

Its Action is Prompt: it stimulates the appetite and the digestion, it promotes assimilation, and it enters directly into the circulation with the food products.

The prescribed dose produces a feeling of buoyancy, and removes depression and melancholy; *hence the preparation is of great value in the treatment of mental and nervous affections.* From the fact, also, that it exerts a double tonic influence, and induces a healthy flow of the secretions, its use is indicated in a wide range of diseases.

## NOTICE--CAUTION.

The success of Fellows' Syrup of Hypophosphites has tempted certain persons to offer imitations of it for sale. Mr. Fellows, who has examined samples of several of these, *finds that no two of them are identical*, and that all of them differ from the original in composition, in freedom from acid reaction, in susceptibility to the effects of oxygen when exposed to light or heat, *in the property of retaining the strychnine in solution*, and in the medicinal effects.

As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, physicians are earnestly requested, when prescribing the Syrup, to write "Syr. Hypophos. **Fellows.**"

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles: the distinguishing marks which the bottles (and the wrappers surrounding them) bear, can then be examined, and the genuineness--or otherwise--of the contents thereby proved.

*Medical Letters may be addressed to:*

Mr. FELLOWS, 48 Vesey St., New York.

PUBLISHER'S



DEPARTMENT.

# The New Orleans Medical and Surgical Journal.

Subscription, Two Dollars per annum, in advance.

Advertisements, as per Printed Schedule mailed to applicants.

NEW SERIES:  
Whole No. 319.

**JULY, 1891.**

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No. 1.

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## PUBLISHERS' NOTES.

NEW ORLEANS.

I CAN safely say that I am partial to "MARIANI WINE OF COCA," when I am in need of a generous tonic  
J. H. WIENDAHL, M. D.

ORLANDO, FLA., January 5, 1891.

*Antikamnia Chemical Co., St. Louis, Mo.*

GENTLEMEN:—I have used Antikamnia, and I am perfectly delighted with the results. I have given it in "La Grippe," Intermittent Neuralgia, and other Neuralgic affections, with the happiest results. I have requested my druggist to order a supply.

Yours truly,

J. W. HINCKS, M. D.

HE WHO assists the physician benefits the race. Use Georgia Bromine Lithia Water, Doctor.

ST. LOUIS, June 21, 1888,

For a long while I have been in the habit of prescribing fluid extract of viburnum prunifolium, in those painful, functional disorders of the uterus and appendages occurring in cases that come under my care for renal and vesical diseases. My results have been satisfactory. Of late, I have given the remedy in the form of DIOVIBURNIA, as prepared by a well-known St. Louis Pharmacist, and the results are equally good, perhaps better; and the method of administration vastly superior.

JOHN P. BRYSON, Professor of Genito-Urinary Organs, St. Louis Medical College.

For the past three years I have prescribed BROMIDIA very frequently, and have never yet been disappointed in securing the results required. In cases when there is Insomnia without pain in the delirious stages of acute fevers, in delirium tremens, puerperal mania, in short, in all those cases requiring soporifics, I find BROMIDIA invaluable. I consider BROMIDIA on excellent combination.

JOSEPH P. ROSS, Professor Clinical Medicine and Diseases of the Chest, Rush Medical College, Chicago, Ill.

BOWDEN LITHIA WATER—under seal—by the gallon. Doctor, try it.

I have a confirmed case of epilepsy on hand having from five to twenty fits a day. I tried Bromide Pot. and Chloral, and while this treatment reduced the attacks considerably, it did not compare with the effects of Peacock's Bromides. I am just in receipt of a letter from the patient's father asking me to send him some more of that medicine for his child, saying that he has not had a fit in three weeks.

BLACK MINGO, S. C.

T. P. STEELE, M. D.

JAS. P. PEELER, M. D., Kissimmee City, Fla., says: I know of nothing with which I have had better success, in treating the various diseases peculiar to the female, than ALETIS CORDIAL. I have used it in amenorrhœa and dysmenorrhœa, with excellent results, and also in ovarian and uterine congestion, and neuralgia, whether from cold or otherwise, I know of no better remedy. Mr. L—— consulted me about his wife. Had been married four years, and had no children. He was a strong healthy man about 28 years of age, and his wife 24. He was very anxious that there should be an increase in the family, and had two other physicians at different times giving her medicine for that purpose. I ascertained that she suffered very much with her menses, and frequently had to take her bed during the time. They were sometimes very scant and at others rather profuse. When consulted it was about a week before her menses would appear. Prescribed

R. ALETIS CORDIAL.....8 ounces.  
Sig. One teaspoonful three times a day.

The husband reported that the wife had the easiest time she ever had, and suffered no pain. When the next time came the menses did not appear, two bottles of ALETIS CORDIAL were taken, and in regular time they were made happy by the advent of a bright bouncing girl. The above is one of several cases of the same kind I have had in my practice. I have been prescribing ALETIS CORDIAL in my practice for about five years, and from its use during that time I have certainly had an opportunity of testing it very well, both singly and combined. When treating females of a weak, nervous, and hysterical condition, caused from uterine derangements, the following will relieve in nearly every case:

R. ALETIS CORDIAL.....8 ounces.  
Celerina.....8 ounces.  
M. Sig. Two teaspoonsful three or four times a day.

The attention of our readers is called to the advertisement of MESSRS. A. ROBINSON & Co., which appears on page 2 of this issue. This house is one of long standing, and enjoys a reputation of the highest character. The preparations referred to, we commend specially to the notice of practitioners.

FOR RENAL HEMORRHAGE.—The following is extremely useful:

R. Ext. Ergotæ fl.....2 ounces.  
Kennedy's Pinus Canadensis (dark).....2 ounces.  
M. Sig. One drachm every hour or two.

DOCTOR, have you tried the famous Bowden Lithia Water?



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## Publishers' Department.

DR. F. A. SMITH, Vinal Haven, Me., writes:—I received the FERRICIDE you sent me and the pills were beyond my expectations. For Neuralgia they cannot be beaten.

---

SANDER & SONS' EUCALYPTI EXTRACT (EUCALYPTOL).—Whenever mention is made of "Oil of Eucalyptus" we beg you to bear in mind that such reference applies to our preparation, styled for distinction: "Eucalypti Extract (Eucalyptol)"; there being manufactured besides our preparation, the wholesale price of which is \$8 per dozen ounce bottles, no oil inclusively produced from the leaves. Other oils of Eucalyptus found in the market—worth about 10 cents an ounce—are common terebinthinous products of no medicinal value. A test will at once convince; the difference is too striking, and allows of no mistake. To avoid disappointment, we would suggest to specify, when prescribing, our manufacture. Samples *gratis* through Dr. Sander, Dillon, Iowa. Meyer Bros., Drug Co., St. Louis, Mo., Sole Agents.

---

ORLANDO, FLA., January 5, 1891.

Antikamnia Chemical Co., St. Louis, Mo.

GENTLEMEN:—I have used Antikamnia, and I am perfectly delighted with the results. I have given it in "La Grippe," Intermittent Neuralgia, and other Neuralgic affections, with the happiest results. I have requested my druggist to order a supply.

Yours truly,

J. W. HINCKS, M. D.

---

HE WHO assists the physician benefits the race. Use Georgia Bromine Lithia Water, Doctor.

---

St. Louis, June 18, 1888,

I have given the DIOVIBURNIA, a fair trial and found it useful as an uterine tonic and antispasmodic, relieving the pains of dysmenorrhea and regulator of the uterine functions. I feel authorized to give this recommendation of DIOVIBURNIA, as it is neither a patented or a secret medicine, the formula of which having been communicated freely to the medical profession.

L. CH. BOISHNIERE, M. D.

---

For the past three years I have prescribed BROMIDIA very frequently, and have never yet been disappointed in securing the results required. In cases when there is Insomnia without pain in the delirious stages of acute fevers, in delirium tremens, puerperal mania, in short, in all those cases requiring soporifics, I find BROMIDIA invaluable. I consider BROMIDIA an excellent combination.

JOSEPH P. ROSS, Professor Clinical Medicine and Diseases of the Chest, Rush Medical College, Chicago, Ill.

---

BOWDEN LITHIA WATER—under seal—by the gallon. Doctor, try it.

---

EPILEPSY. HYSTERIA.—I have used Peacock's Bromides extensively in epilepsy and hysteria; two cases of epilepsy of twelve and fifteen years standing have not returned for two years.

C. W. TOWNSEND, M. D., Bower Hill, Pa.

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The attention of our readers is called to the advertisement of the LONDONDERRY LITHIA WATER which appears on page 2 of this issue.

---

IMPOTENCY AND SPERMATORRHEA.—Having a large practice in the treatment of the above named diseases—impaired sexual vigor—I frequently would find in some of the most inveterate cases, after having restored them to their youthful vigor and manhood, a peculiar neurasthenia, due, undoubtedly, to reflex nerve irritation, which I was unable to control until I gave the preparation: *Neurostine*—which was recommended to me by a professional brother—a trial, and I must unhesitatingly say its action was almost magical in relieving some of my worst cases of nervous prostration, and I am confident that it is almost a specific in treating loss of sexual appetite and spermatorrhœa, any case of that kind can be quickly and permanently cured, and if the preparation and results continue so highly satisfactory, I shall prescribe it in the future in preference to all preparations for neurotic troubles that I have ever used.

AMBROSE PAGE, M. D., Rushmore, Ohio.

---

FOR RENAL HEMORRHAGE.—The following is extremely useful:

R. Ext. Ergotæ fl.....	2 ounces.
Kennedy's Pinus Canadensis (dark).....	2 ounces.
M. Sig. One drachm every hour or two.	

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DOCTOR, have you tried the famous Bowden Lithia Water?

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DEPARTMENT.

# The New Orleans Medical and Surgical Journal.

Subscription, Two Dollars per annum, in advance.

Advertisements, as per Printed Schedule mailed to applicants.

NEW SERIES:

Whole No. 321.

**SEPTEMBER, 1891.**

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No. 3.

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NEW ORLEANS.

I CAN safely say that I am partial to "MARIANI WINE OF COCA," when I am in need of a generous tonic

J. H. WIENDAHL, M. D.



## Publishers' Department.

DR. F. A. SMITH, Vinal Haven, Me., writes:—I received the FERRICIDE you sent me and the pills were beyond my expectations. For Neuralgia they cannot be beaten.

SANDER & SONS' EUCALYPTI EXTRACT (EUCALYPTOL).—Whenever mention is made of "Oil of Eucalyptus" we beg you to bear in mind that such reference applies to our preparation, styled for distinction: "Eucalypti Extract (Eucalyptol)"; there being manufactured besides our preparation, the wholesale price of which is \$8 per dozen ounce bottles, no oil inclusively produced from the leaves. Other oils of Eucalyptus found in the market—worth about 10 cents an ounce—are common terbinthinous products of no medicinal value. A test will at once convince; the difference is too striking, and allows of no mistake. To avoid disappointment, we would suggest to specify, when prescribing, our manufacture. Samples *gratis* through Dr. Sander, Dillon, Iowa. Meyer Bros., Drug Co., St. Louis, Mo., Sole Agents.

A DIURETIC THAT WILL NOT DISAPPOINT YOU.—There is so much offered the profession that is worthless, that a combination of real value is apt to be overlooked or slighted. So many diseases require stimulation of the Urinary Secretions, that a real good diuretic of eligible form should be hailed as a boon. Such, we know Wayne's Elixir to be. An examination of its ingredients will show that it is composed of the best known and most popular diuretics in the U. S. P., and we confidently believe if our readers in this and adjoining states were to give it an impartial trial, they would add it to their list of reliable resources.

HE WHO assists the physician benefits the race. Use LONDONDERRY LITHIA WATER.

ST. LOUIS, June 18, 1888,

I have given the DIOVIBURNIA, a fair trial and found it useful as an uterine tonic and antispasmodic, relieving the pains of dysmenorrhea and regulator of the uterine functions. I feel authorized to give this recommendation of DIOVIBURNIA, as it is neither a patented or a secret medicine, the formula of which having been communicated freely to the medical profession.

L. CH. BOISHNIERE, M. D.

For the past three years I have prescribed BROMIDIA very frequently, and have never yet been disappointed in securing the results required. In cases when there is Insomnia without pain in the delirious stages of acute fevers, in delirium tremens, puerperal mania, in short, in all those cases requiring soporifics, I find BROMIDIA invaluable. I consider BROMIDIA an excellent combination.

JOSEPH P. ROSS, Professor Clinical Medicine and Diseases of the Chest, Rush Medical College, Chicago, Ill.

ROSSVILLE, STATEN ISLAND, July 16, 1891.

Antikamnia Chemical Co., St. Louis, Mo.

GENTLEMEN:—After using continuously in my practice, eight ounces of Antikamnia, pure and simple, in all the diseases for which you recommended it; I assure you, unsolicited, that it has fulfilled every promise you made. After nearly twenty-five years of hospital and private practice, I would rather abandon Morphine than Antikamnia, which, I also consider an unequalled febrifuge. Indeed its antipyretic qualities are wonderful in reducing the temperature. I have never had a patient object to taking the dry powder on the tongue, nor had one complain of feeling the slightest malaise after its administration. I know I am making sweeping assertions, but you should know the truth so as to be encouraged in your work.

Truly,

CALEB LYON, M. D.

The attention of our readers is called to the advertisement of the LONDONDERRY LITHIA WATER which appears on page 2 of this issue.

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NEW SERIES:  
Whole No. 322.

**OCTOBER, 1891.**

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Truly,

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ROSSVILLE, STATEN ISLAND, July 16, 1891.

DR. N. M. GRAY, of Alleghany, Pa., says: "I have tried PAPINE in two cases and with best effects. Both were cases of children from one to three years old, and both so complicated with cerebral trouble that I feared to use opium or any of its preparations, and yet I wished for an anodyne to control some very marked symptoms. So I tried the PAPINE, and am happy to say that it had the desired effect, without any of the unpleasant consequences so often following the use of the drug in any form I have heretofore used. I think it an excellent preparation for that class of diseases, and I intend to use it hereafter."

---

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NEW SERIES:  
Whole No. 323.

**NOVEMBER, 1891.**

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To overcome the appetite for strong drink we must employ a remedial agent which, while acting as a stimulant and tonic on the system, will cause no disgust for it or nausea when its use is continued for some time. In *CELERINA*, we have almost a certain cure, *CELERINA*, while causing no nausea whatever through and by itself, will, in most cases, as extensive experience has proven, imbue the person using it with an actual disgust for, and an abhorrence of, all kinds of strong drink. In the varied conditions following the abuse of alcohol, opium, and tobacco, to restore the patient and tone the nervous system, *CELERINA* is of great value, and as a tonic to the nervous system in all these cases of nervous exhaustion, whether evolved in the cerebral or spinal centers. *CELERINA*, in doses of a fluid drachm three times a day, destroys the craving for alcoholic liquors. *CELERINA* is a remedy par excellence to tone the nervous system in the varied conditions following sexual excesses and the abuse of alcohol, opium and tobacco.

**EPILEPSY.**—In a case of epilepsy of several years' standing I have used Peacock's Bromides with perfect satisfaction to myself and patient. It controls the spasms perfectly and seems to agree well with the stomach.

West Jefferson, Ohio.

W. E. POSTLE, M. D.

**PONCA COMPOUND** exercises a decided and specific alterative action upon the uterine tissues as also a general tonic influence upon the pelvic organs. It has a tendency to absorb plastic deposits, to regulate the vascular supply and thus relieve congestion; to encourage peristaltic action of the bowels; to tone up the nerve forces and thus remove spasmodic conditions. In most instances it eradicates the principal influences that cause and keep up engorgements, displacements, etc., and can always be relied upon as the chief factor in bringing about normal condition. Its range of uses is well indicated by its formula:—

Ext. Ponca .....	3 grains.
Ext. Mitchella Repens .....	1 grain.
Caulophyllin .....	$\frac{1}{4}$ grain.
Helonin .....	$\frac{1}{2}$ grain.
Viburnin .....	$\frac{1}{2}$ grain.

100 Tablets will be mailed upon receipt of \$1.00 by the MELLIER DRUG CO., St. Louis.

JUDGING from Armour & Company's extensive advertising and sampling, it would appear as though they don't care how many physicians know that they prepare a line of elegant digestive ferments. Everybody already knows, we might say, that Armour & Co. produce their own raw materials, hence the usual deterioration during transportation is avoided, with the obviously important consequences of entire absence of toxic principles in their products, and their unusually high tests. Armour & Co. state that they have every advantage necessary to their being headquarters in the line of digestive ferments, as they are already in extract of beef, not only in quality, but in price. For further information we refer our readers to advertisement on page 33.

### PERSPIRATION OF THE FEET.—

R. Glycerine .....	1 OZ.
Kennedy's Ext. Pinus Can .....	1 OZ.
Aque .....	2 OZ.
Essence of Bergamot .....	2 drachms.

Mix and apply twice each day. The results are surprisingly rapid and happy.

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DECEMBER, 1891.

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*Dade City, Fla.*

J. G. WALLACE, M. D.

**QUININE PILLS AND CAPSULES ARE VERY INSOLUBLE, OFTEN BEING DISCHARGED UNDISSOLVED.**—Febriline, or Tasteless Syrup of Quinine, has been found to be just as reliable in all cases, as the bitter Sulphate of Quinine, and physicians will find it to their interest to use it for adults, as well as children, in place of pills and capsules. The price has been reduced 33⅓% which makes it as cheap to the consumer as Quinine pills or capsules. It is as pleasant as Lemon Syrup, and will be retained by the most delicate stomach, having also the advantage of not producing the unpleasant head symptoms, of which so many patients complain, after taking the Quinine Sulphate. Possessing these advantages, physicians will find it superior to the Quinine Sulphate, for all cases requiring Quinine—particularly typhoid fever patients.

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*Extract from letter, W. F. Glenn, M. D., Professor of Genital-Urinary Diseases in the Medical Department of the University of Tennessee.*

No practitioner passes many days, or seldom many hours, without being called upon to prescribe for some real or imaginary disease of the kidneys. While such serious disorders as diabetes and Bright's disease, in which these organs are fatally involved, are occasionally met with, they are few as compared with the many minor affections, not only in the kidneys themselves, but on all parts of the genito-urinary tract. Catarrh of the kidneys, ureter, bladder or urethra, irritations and congestions of the various parts of the urinary apparatus, are as common as bad colds. What is more frequent than patients complaining of pain in the back, in the region of the kidneys, with or without a scant flow of urine, or a burning sensation in the neck of the bladder or urethra on voiding urine, and numbers of other similar ailments. In all forms of functional derangements of these important excretory organs the administration of a gentle but effective diuretic generally affords relief. Where an analysis of urine proves the absence of elements that would indicate serious organic lesions it is a safe, and in fact, a proper course to use a remedy that will stimulate to gentle action the cells of the kidneys, thereby increasing the watery portions of the urine. Such a course will rarely fail to effect a cure.

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*Extract from letter Dr Thep. Jasper, 322 South Sixth street, Columbus, Ohio.*

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J. LINDSAY PORTEOUS,  
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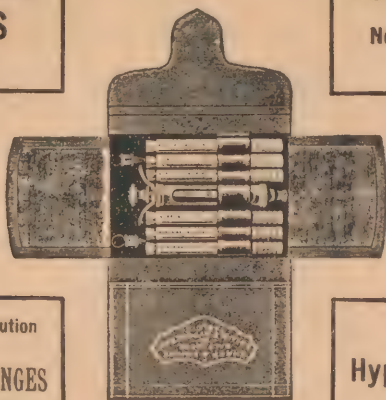
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Transactions of the Fourth Annual Meeting of the American Climatological Association, held in the  
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SPRINGVIEW, NEB., Nov. 25, 1889.

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William Johnson,	June 1, 1889,	June 8, 1889.		Belle Smith,	Jan. 8, 1890,	Jan. 12, 1890.	
Fanny Winnery,	Dec. 29, 1889,	Jan. 4, 1890.		Wm. Payne,	Jan. 2, 1890,	Jan. 5, 1890.	
William M. Johnson,	Dec. 30, 1889,	Jan. 5, 1890.		Gustav Thoman,	Jan. 21, 1890,	Jan. 23, 1890.	

All ended in recovery. These are all the cases of croupous or lobar pneumonia treated in the hospital during the influenza epidemic excepting one case, which was admitted in a moribund condition, and died before any treatment could be instituted. One case, which was apparently moribund when admitted, is included in the above list, and is at present recovering from an attack of femoral phlebitis. JOHN A. REYBURN, M. D., Resident Physician. *Phila. Times and Register*, Feb. 17, 1890

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*Extract from letter, W. F. Glenn, M. D., Professor of Genital-Urinary Diseases in the Medical Department of the University of Tennessee.*

No practitioner passes many days, or seldom many hours, without being called upon to prescribe for some real or imaginary disease of the kidneys. While such serious disorders as diabetes and Bright's disease, in which these organs are fatally involved, are occasionally met with, they are few as compared with the many minor affections, not only in the kidneys themselves, but on all parts of the genito-urinary tract. Catarrh of the kidneys, ureter, bladder or urethra, irritations and congestions of the various parts of the urinary apparatus, are as common as bad colds. What is more frequent than patients complaining of pain in the back, in the region of the kidneys, with or without a scant flow of urine, or a burning sensation in the neck of the bladder or urethra on voiding urine, and numbers of other similar ailments. In all forms of functional derangements of these important excretory organs the administration of a gentle but effective diuretic generally affords relief. Where an analysis of urine proves the absence of elements that would indicate serious organic lesions it is a safe, and in fact, a proper course to use a remedy that will stimulate to gentle action the cells of the kidneys, thereby increasing the watery portions of the urine. Such a course will rarely fail to effect a cure.

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*Extract from letter Dr Theo. Jasper, 322 South Sixth street, Columbus, Ohio.*

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J. LINDSAY PORTEOQS,

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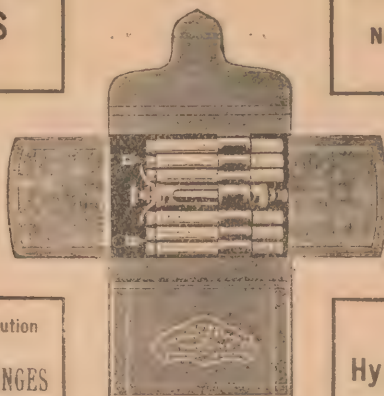
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MARTIN LUTHER, M. D.

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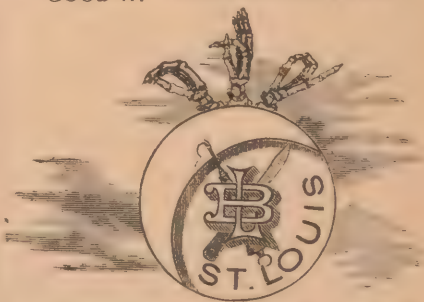
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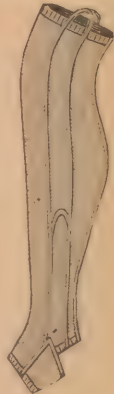


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William M. Johnson,	Dec. 30, 1889,	Jan. 5, 1890,		Gustav Thoman,	Jan. 21, 1890,	Jan. 23, 1890,	

All ended in recovery. These are all the cases of croupous or lobar pneumonia treated in the hospital during the influenza epidemic excepting one case, which was admitted in a moribund condition, and died before any treatment could be instituted. One case, which was apparently moribund when admitted, is included in the above list, and is at present recovering from an attack of femoral phlebitis. JOHN A. REYBURN, M. D., Resident Physician.—*Phila. Times and Register*, Feb. 17, 1890

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The drainage is as near perfect as Sanitary science will make it. The house-keeping will be in charge of a most **Cultured and Experienced Lady**, who is widely known for her excellence and superior merit in this particular. The

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Where everything will be as near **ASEPTIC** as possible, in charge of nurses educated and trained especially for this purpose, will be an especial feature of the Institution.

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Under same roof but disconnected with the main building, will be made as near **ASEPTIC** as it can be. I have a full corps of competent Physicians to assist me. A resident Physician, with a cottage on the grounds, will be in constant attendance. My nurses are all ladies of education and training in the profession, most of them coming direct from the Woman's Hospital, New York.

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## SYRUP OF FIGS,

An agreeable and effective laxative or purgative according to the dose and manner of administration.

Syrup of Figs is delightful to the taste and may be taken by every one from infancy to old age.

Syrup of Figs does not debilitate and is perfectly safe.

The dose as a purgative for an adult is from one-half to one tablespoonful, and may be repeated in six hours if required. As a laxative, one or two teaspoonfuls may be given at bed time, or before breakfast.

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*Composed of Buchu, Juniper, Acetate of Potash, Etc.*

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**INDICATIONS.**—Acute and Chronic Catarrh of the Bladder. Brick Dust and Chalky Deposits in the Urine, Gravel, etc. Acute and Chronic Bright's Disease, Lumbago, and in Acute and Chronic Rheumatism.

Prescribed and endorsed by the leading physicians of the United States. It is giving universal satisfaction in the profession. It seems to be ALMOST A SPECIFIC for Diseases of the Genito-Urinary Organs.

*Extract from letter, W. F. Glenn, M. D., Professor of Genital-Urinary Diseases in the Medical Department of the University of Tennessee.*

No practitioner passes many days, or seldom many hours, without being called upon to prescribe for some real or imaginary disease of the kidneys. While such serious disorders as diabetes and Bright's disease, in which these organs are fatally involved, are occasionally met with, they are few as compared with the many minor affections, not only in the kidneys themselves, but on all parts of the genito-urinary tract. Catarrh of the kidneys, ureter, bladder or urethra, irritations and congestions of the various parts of the urinary apparatus, are as common as bad colds. What is more frequent than patients complaining of pain in the back, in the region of the kidneys, with or without a scant flow of urine, or a burning sensation in the neck of the bladder or urethra on voiding urine, and numbers of other similar ailments. In all forms of functional derangements of these important excretory organs the administration of a gentle but effective diuretic generally affords relief. Where an analysis of urine proves the absence of elements that would indicate serious organic lesions it is a safe, and in fact, a proper course to use a remedy that will stimulate to gentle action the cells of the kidneys, thereby increasing the watery portions of the urine. Such a course will rarely fail to effect a cure.

For this purpose there is nothing superior to buchu, juniper, acetate of potash, corn silk and digitalis. The action of many of this class of remedies, such as corn silk, juniper, eucalyptus, etc., have a more or less specific influence on bladder and urethral irritations and inflammations.

Some years since my attention was attracted to a remedy styled Wayne's Diuretic Elixir, which, upon examination, I found to be a combination of acetate of potash, juniper and buchu, prepared in such a manner as not to be unpleasant, but rather agreeable to the taste, and accurate in its proportions. Being easier to prescribe and far more pleasant to the patient than the same remedies freshly mixed in the drug store, I began to use it in all irritations of the kidneys, bladder, urethra and prostate gland, and have found it to meet every indication. Now, when I desire a mild diuretic effect continued for some time, I rarely depart from this mixture. Prof. Deering J. Roberts, surgeon to the State Prison, has been using it largely of late at the hospital of that institution, and reports it perfectly satisfactory. Case after case taken from my own and from other record books could be cited to show its satisfactory effects, but that is hardly necessary. And while I am not an advocate of the wholesale use of all the various preparations that are now crowded upon us, at the same time, after thoroughly testing this one for some years, I feel that it will not be amiss to present its virtues to the profession. Not for any new virtues that its ingredients may possess, for they have been understood for many years, but because of its careful preparation and pleasant taste, and thereby great utility. From the very highly satisfactory results obtained by me for the past five years, I am quite sure its use will be attended with no disappointment or regret.

*Extract from letter Dr Theo. Jasper, 322 South Sixth street, Columbus, Ohio.*

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Iodia is a Combination of active principles obtained from the Green Roots of Stillingia, Helonias, Saxifraga, Menispermum and Aromatics. Each fluid drachm also contains five grains Iod. Potas., and three grains Phos. Iron.

### DOSE.—

One or two fluid drachms (more or less as indicated) three times a day, before meals.

### INDICATIONS.—

Syphilitic, Scrofulous and Cutaneous Diseases, Dysmenorrhea, Menorrhagia, Leucorrhoea, Amenorrhoea, Impaired Vitality, Habitual Abortions and General Uterine Debility.

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MILK  
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PARTIALLY PEPTONIZED

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### A SEDATIVE NERVE AND BRAIN FOOD.

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Each dessertspoonful contains: Caffein. Acidi Phosphorici,  $\frac{1}{100}$  grains, ss. Antipyrin. Ext. Apii. Grav. Dulc. (Celery)  $\frac{1}{100}$  grain j. Sodium Bromide, grains v.

**DOSE.**—One or two heaping teaspoonfuls in a half tumbler of water. Put up in 4 oz. and 8 oz. Bottles.

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Metrorrhagia,  
Leucorrhœa,  
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

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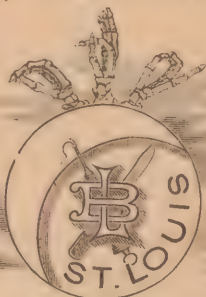
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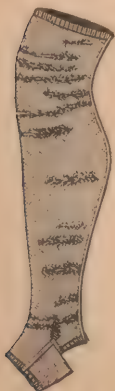


Fig. 1.

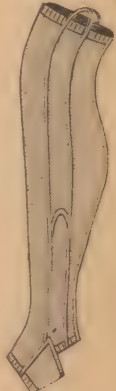


Fig. 2.

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Where everything will be as near **ASEPTIC** as possible, in charge of nurses educated and trained especially for this purpose, will be an especial feature of the Institution.

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Under same roof but disconnected with the main building, will be made as near **ASEPTIC** as it can be. I have a full corps of competent Physicians to assist me. A resident Physician, with a cottage on the grounds, will be in constant attendance. My nurses are all ladies of education and training in their profession, most of them coming direct from the Woman's Hospital, New York.

I refer by permission to Dr. G. W. MULLIGAN, President Georgia State Medical Association, Washington, Ga.; Drs. J. S. TODD and A. W. CALHOUN, ex-Presidents Georgia State Medical Association, Atlanta, Ga. Also the following gentlemen, Censors Georgia State Medical Association: Drs. EUGENE FOSTER, Augusta, Ga.; B. R. DOSTER, Blakely, Ga.; MARK H. O'DANIEL, Milledgeville, Ga.; K. P. MOORE and H. McHATTON, Macon, Ga., or any member in good STANDING of the Georgia State Medical Association.

Physicians sending me patients may rest assured that they will receive the best care and attention in every particular, and reports will be made every few days. Special rates will be made for the wives and daughters of Physicians and Clergymen.

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Is used in gonorrhea, leucorrhea, ulceration of the cervix uteri and vagini, cystitis, nephritis, stomatitis, dyspepsia, constipation, ophthalmi taasi, conjunctivitis, catarrh of the intestines, painful menstruation, and as a local application to prevent decomposition, as an injection into the bowels in diarrhea and dysentery, and to correct the offensive character of many mucous discharges.

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Is utilizing the delicious Blue Fig of California in the preparation of

## SYRUP OF FIGS,

An agreeable and effective laxative or purgative according to the dose and manner of administration.

Syrup of Figs is delightful to the taste and may be taken by every one from infancy to old age.

Syrup of Figs does not debilitate and is perfectly safe.

The dose as a purgative for an adult is from one-half to one tablespoonful, and may be repeated in six hours if required. As a laxative, one or two teaspoonfuls may be given at bed time, or before breakfast.

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Is recommended and prescribed by prominent physicians in all sections of the United States and gives general satisfaction.

In addition to the Blue Figs of California, we use the juice of true Alexandria Senna, representing the laxative and purgative principles without its griping properties, also pure white sugar and an excellent combination of carminative aromatics.

Devoting our entire attention to the manufacture of Syrup of Figs after thorough study of the results to be accomplished and of the best methods to produce a perfect laxative, and with complete manufacturing facilities especially adapted to the purpose, we are enabled to offer to the medical profession, in Syrup of Figs, a laxative which though simple in itself, cannot be produced in all its excellence by other parties, and we believe and trust that physicians will not permit imitations to be used when they prescribe Syrup of Figs (Syr. Fici Cal.)

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*Composed of Buchu, Juniper, Acetate of Potash, Etc.*

## DIURETIC AND ALTERATIVE.

**INDICATIONS.**—Acute and Chronic Catarrh of the Bladder. Brick Dust and Chalky Deposits in the Urine, Gravel, etc. Acute and Chronic Bright's Disease, Lumbago, and in Acute and Chronic Rheumatism.

Prescribed and endorsed by the leading physicians of the United States. It is giving universal satisfaction in the profession. It seems to be **ALMOST A SPECIFIC** for Diseases of the Genito-Urinary Organs.

*Extract from letter, W. F. Glenn, M. D., Professor of Genital-Urinary Diseases in the Medical Department of the University of Tennessee.*

No practitioner passes many days, or seldom many hours, without being called upon to prescribe for some real or imaginary disease of the kidneys. While such serious disorders as diabetes and Bright's disease, in which these organs are fatally involved, are occasionally met with, they are few as compared with the many minor affections, not only in the kidneys themselves, but on all parts of the genito-urinary tract. Catarrh of the kidneys, ureter, bladder or urethra, irritations and congestions of the various parts of the urinary apparatus, are as common as bad colds. What is more frequent than patients complaining of pain in the back, in the region of the kidneys, with or without a scant flow of urine, or a burning sensation in the neck of the bladder or urethra on voiding urine, and numbers of other similar ailments. In all forms of functional derangements of these important excretory organs the administration of a gentle but effective diuretic generally affords relief. Where an analysis of urine proves the absence of elements that would indicate serious organic lesions it is a safe, and in fact, a proper course to use a remedy that will stimulate to gentle action the cells of the kidneys, thereby increasing the watery portions of the urine. Such a course will rarely fail to effect a cure.

For this purpose there is nothing superior to buchu, juniper, acetate of potash, corn silk and digitalis. The action of many of this class of remedies, such as corn silk, juniper, eucalyptus, etc., have a more or less specific influence on bladder and urethral irritations and inflammations.

Some years since my attention was attracted to a remedy styled Wayne's Diuretic Elixir, which, upon examination, I found to be a combination of acetate of potash, juniper and buchu, prepared in such a manner as not to be unpleasant, but rather agreeable to the taste, and accurate in its proportions. Being easier to prescribe and far more pleasant to the patient than the same remedies freshly mixed in the drug store, I began to use it in all irritations of the kidneys, bladder, urethra and prostate gland, and have found it to meet every indication. Now, when I desire a mild diuretic effect continued for some time, I rarely depart from this mixture. Prof. Deering J. Roberts, surgeon to the State Prison, has been using it largely of late at the hospital of that institution, and reports it perfectly satisfactory. Case after case taken from my own and from other record books could be cited to show its satisfactory effects, but that is hardly necessary. And while I am not an advocate of the wholesale use of all the various preparations that are now crowded upon us, at the same time, after thoroughly testing this one for some years, I feel that it will not be amiss to present its virtues to the profession. Not for any new virtues that its ingredients may possess, for they have been understood for many years, but because of its careful preparation and pleasant taste, and thereby great utility. From the very highly satisfactory results obtained by me for the past five years, I am quite sure its use will be attended with no disappointment or regret.

*Extract from letter Dr Theo. Jasper, 322 South Sixth street, Columbus, Ohio.*

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Every fluid drachm contains fifteen grains EACH of Pure Chloral Hydrat, and purified Brom. Pot. and one-eighth grain EACH of gen. im. ext. Cannabis Ind. and Hyoscyam.

### DOSE.—

One-half to one fluid drachm in WATER or SYRUP every hour, until sleep is produced.

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Sleeplessness, Nervousness, Neuralgia, Headache, Convulsions, Colic, Mania, Epilepsy, Irritability, etc. In the restlessness and delirium of fevers it is absolutely invaluable.

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## THE ANODYNE.

Papine is the Anodyne or pain-relieving principle of Opium, the Narcotic and Convulsive Elements being eliminated.

It has less tendency to cause Nausea,  
Vomiting, Constipation, Etc.

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Same as Opium or Morphia.

### DOSE.—

ONE FLUID DRACHM—(represents the Anodyne principle of one-eighth grain of Morphia.)

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## THE ALTERATIVE AND UTERINE TONIC.

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Iodia is a Combination of active principles obtained from the Green Roots of Stillingia, Helonias, Saxifraga, Menispermum and Aromatics. Each fluid drachm also contains five grains Iod. Potas., and three grains Phos. Iron.

### DOSE.—

One or two fluid drachms (more or less as indicated) three times a day, before meals.

### INDICATIONS.—

Syphilitic, Scrofulous and Cutaneous Diseases, Dysmenorrhea, Menorrhagia, Leucorrhoea, Amenorrhoea, Impaired Vitality, Habitual Abortions and General Uterine Debility.

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Convalescence from all diseases, Pulmonary Affections, Pneumonia, Phthisis, Dyspepsia, Gastritis, and all Stomach Ailments; Fevers, Diarrhœa, Dysentery, and all Intestinal Diseases; Marasmus, Bright's Disease, Diabetes and Excessive Use of Alcoholic Stimulants. Beef Peptonoids may be given per rectum in all cases where the stomach cannot digest food, and in Debility resulting from any cause.

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This preparation represents Beef Peptonoids in the form of an elegant cordial, all constituents being entirely digested and ready for assimilation.

Liquid Peptonoids is a nourishing peptogenic liquid stimulant with the albuminoids in a soluble state with only sufficient spirits added to preserve it. It contains the largest amount of albuminoid principles and the least amount of alcohol that is possible to use and make a stable compound.

Liquid Peptonoids will keep indefinitely; its flavor and palatability are such that many who have taken it liken it to a delicate cordial. It will readily be taken by patients who are unable to digest food in any other form (in these cases it has been found of the greatest service). In convalescence from fever and other diseases, in loss of appetite, weak digestion and gastritis its effects are positive, and it will never fail to give perfect satisfaction.

There is no preparation in the market that has been recommended so highly by physicians who have carefully tested it.

**DOSE.**—For an adult, one tablespoonful three times to six times a day; children in proportion.

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### A SEDATIVE NERVE AND BRAIN FOOD.

The most efficient and palatable preparation in Nervous and Sick Headache, Neuralgia, Insomnia, Neurasthenia and General Nervous Irritability.

Each dessertspoonful contains: Caffein. Acidi Phosphorici,  $\frac{1}{100}$  grains, ss. Antipyrin. Ext. Apii. Grav. Dulc. (Celery)  $\frac{1}{100}$  grain j. Sodium Bromide, grains v.

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Gentlemen: This is to certify that your preparation known as the CREAM KUMYSS contains no chemical substance foreign to pure milk, and furthermore, that its susceptibility of keeping, without spoiling, is only due to the purity of the milk and the excellent scientific precautions used in the process of fermentation.

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Pure Pepsin .....	1 gr.
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Acid Lacto-Phosphate of Calcium .....	
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The **Pepsin** and **Pancreatin** used in these tablets possess highest digestive power, and cannot fail to promptly start and accomplish

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Whilst the **Caffeine**, by its stimulant tonic action on stomach and bowels, assists and quickens the normal digestion and assimilation of food, the **Acid Lacto-Phosphate of Calcium** contributes to the tonic action of the tablets, and aids to build up the general system, and a small quantity of that refreshing aromatic nerve stimulant, **Celery**, imparts a pleasant flavor and acts as an appetizer.

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Having used your Tarrant's Seltzer Aperient in my practice for the past twenty years, I can truthfully indorse it as the best Aperient I have ever prescribed for disorders of the stomach, dyspepsia and for constipation of pregnancy. In fact I know of no other Aperient to equal it.

I have recently found it a splendid vehicle for the administration of tincture of iron. It overcomes the constipating effect, neutralizes the acid so that it does not affect the teeth, and disguises the taste of the iron perfectly.

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V. Pepsin and Charcoal—Pepsin 1 grain, Charcoal 2 grains.

IV. Pepsin Comp.—Pepsin 1 grain, Pancreatin  $\frac{1}{2}$  grain, Lactophos. Lime  $2\frac{1}{2}$  grains.

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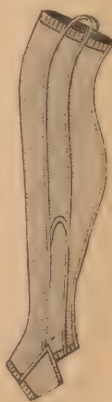


Fig. 2.

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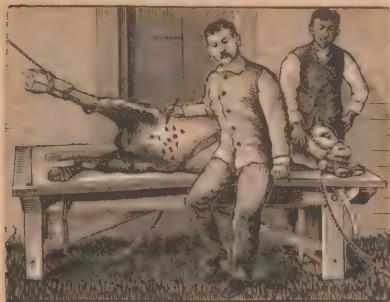
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has won its way into the confidence of the physicians by giving almost universal satisfaction. It is the most perfect solvent of

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known, and has a peculiar power to control the resulting Rheumatism. Gout, Gravel and usual train of lithemic symptoms.

The endorsements of hundreds of eminent Physicians have been published from time to time. To any Physician who will apply we will furnish any desired evidence bearing upon the clinical effects of

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**EUROPHEN** is the most interesting of the new Iodine compounds, for it not only acts as a perfect substitute for Iodoform, but seems likely to largely displace Mercury and Iodine in the internal treatment of Constitutional Syphilis. This at least is the opinion of Seifert, Eichhoff and Petersen, who used it hypodermically in this condition, with surprisingly good results. The same writers found also, that **EUROPHEN** possesses remarkable curative power in Obstinate Dermatoses, in Atrophic and Secretory Rhinitis, in Ulcerative Conditions, in Inflammations of the Mucous Surfaces, etc.

**EUROPHEN** is prepared only by the Farbenfabriken, formerly Friedr. Bayer & Co., of Elberfeld, and is supplied in ounces.

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The safest of antithermics, and the most prompt and effective in action, **PHENACETINE-BAYER** continues to hold its high position as an Antipyretic, Analgesic, Anti-rheumatic and Anti-neuralgic. In all Acute Inflammatory Fevers, Bronchitis, Phthisis, Rheumatism, Influenza, Migraine, Whooping-cough, etc., it has given most satisfactory results.

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**SULFONAL-BAYER** is justly regarded as a true nerve sedative, as well as a hypnotic, on account of its prolonged good effect. It is of the highest value in the Insomnia of Nervous and Febrile conditions, in the Symptomatic Treatment of Insanity, and all cases in which Hypnotics are indicated. To obtain its best effects, **SULFONAL** must be administered in a manner suited to its nature.

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## ARISTOL.

**ARISTOL**, as a succedaneum of Iodoform, has met with remarkable success. It is safe and effective in all Ulcerations, in Skin Diseases, in Lesions of the Eye, Ear, Nose, Mouth and other cavities, in Dysentery, Gonorrhœa, Ivy-poisoning, Burns, Scalds, Blisters, and all external Traumatisms. It is used in ointments, powders, crayons, suppositories, balls, oils, sprays, collodions, plasters, tampons, bandages, etc.

**ARISTOL GAUZE** is now widely used by American Surgeons in place of Iodoform, so long offensive to both Physician and patient.

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**Prof. WM. A. HAMMOND, M. D.,** says: A wineglassful of this tonic, taken when one is exhausted and worn out, acts as a most excellent restorative; it gives a feeling of rest and relief, and there is no reaction and no subsequent depression. A general feeling of pleasantness is the result. **I have discarded other wines of coca and use this alone.** It produces also excellent results in cases of depression of spirits; in hysteria, headache, and in nervous troubles generally it works admirably. It is a simple remedy, yet efficacious and remarkable in its results.

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*A Complete Antipyretic, a Restorative of the Highest Order, and an Anodyne of Great Curative Power.*

On November 6th I was called in consultation to see Mr. W., who was suffering from the most violent attack of ANTHRA, the paroxysm so frequent that suffocation seemed only a matter of a short time. We gave him one "FEBRICIDE PILL" and ordered one every two hours: ordered hot mustard foot-bath; his doctor remained with him. I returned per request in seven hours: to my surprise, he was breathing, talking, and, as he informed me, felt first-rate.

**DR. D. W. MCCARTHY.**

SPRINGVIEW, NEB., Nov. 25, 1889.

I have used your FEBRICIDE with excellent results in our Mountain Fevers (typhoid), reducing, in one case, the temperature from  $104\frac{1}{2}$  with dry, brown furried tongue in ten hours, to  $99\frac{1}{2}$  with tongue cleaning promptly and moist, and rapid improvement dating therefrom. Have used Antipyrin in similar cases with no good results.

**ALBERT S. WARNER, M. D.**

# NATROLITHIC SALT

Containing Sulphate of Soda, Carbonate of Soda, Phosphate of Soda, Chloride of Sodium, Sulphate of Lime, Sulphate of Magnesia, and Carbonate of Lithia. For Habitual Constipation, Rheumatic and Gouty Affections, Bilioussness, Corpulencé, Dyspepsia, and all Derangements of the Digestive Tract, it is a wonderful remedy. *Does not gripe after administration.*

**GRAND RAPIDS, MICH., October 8, 1889.**

"Febrihide Pills" have been used in a case of CHILLS from SEPTIC POISONING and worked to perfection, as they stopped them entirely where ordinary QUINIA HAD FAILED. Also kept down the temperature. **O. E. HERRICK, M. D.**

## FEBRICIDE PILLS IN PNEUMONIA.

The following cases of Pneumonia were treated in the Medico-Chirurgical Institute, of Philadelphia, with the Febrihide Pills (one being given every four hours, as a rule), and with hot poultices externally:

Admitted.		Crisis.		Admitted.		Crisis.	
William Johnson,	June 1, 1889,	June 8, 1889,		Belle Smith,	Jan. 8, 1890,	Jan. 12, 1890,	
Fanny Winery,	Dec. 29, 1889,	Jan. 4, 1890,		Wm. Payne,	Jan. 2, 1890,	Jan. 5, 1890,	
William M. Johnson,	Dec. 30, 1889,	Jan. 5, 1890,		Gustav Thoman,	Jan. 21, 1890,	Jan. 23, 1890,	

All ended in recovery. These are all the cases of croupous or lobar pneumonia treated in the hospital during the influenza epidemic excepting one case, which was admitted in a moribund condition, and died before any treatment could be instituted. One case, which was apparently moribund when admitted, is included in the above list, and is at present recovering from an attack of femoral phlebitis. **JOHN A. REYBURN, M.D.,** Resident Physician. *Phila. Times and Register, Feb. 17, 1890.*

Samples will be sent free of charge to any Physician who may wish to examine same.

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# VIN MARIANI

Continued use in Hospital, Clinic and Private practice during thirty years,  
demonstrates "VIN MARIANI" deservedly  
holds its position as

## "THE STANDARD PREPARATION OF ERYTHROXYLON COCA."

Upward of Seven Thousand Practitioners have furnished data, clearly proving the  
efficacy and merits of "VIN MARIANI," thus summarized:

"DIFFUSIBLE STIMULANT AND TONIC in anæmia,  
nervous depression, sequelæ of childbirth, lymphatism,  
tardy convalescence, general 'MALAISE,' and after  
wasting fevers."

"SPECIAL reference to the nervous system, in all morbid  
states, melancholia, etc."

"TONIC in laryngeal and gastric complications, stomach  
troubles."

"All cases where general toning or strengthening of the  
system is needed."

"The only tonic stimulant without any unpleasant re-  
action, and may be given indefinitely, never causing  
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**N. B.**

This Wine has been found always uniform and reliable, owing  
to the selection of finest ingredients and the greatest accuracy  
in its manipulation. When prescribing, therefore, the Medi-  
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THE

# VIBURNUM COMPOUND

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Is the accepted standard in the Ailments of

## WOMEN AND OBSTETRICS.

It is the only reliable remedy in **DYSMENORRHEA**.

It is superior to **ERGOT** in any and all cases.

It is a fact, that HAYDEN'S VIBURNUM COMPOUND antedates all other preparations in this country containing Viburnum, no exceptions, and not one of them would have ever had an existence had it not have been for the available reputation of Hayden's VIBURNUM COMPOUND.

It is perfectly safe in any and all cases; contains no poison, narcotic, and has no sequelæ.

For Hand Books free, containing formula, special directions and thousands of Professional Testimonials, send your address to the

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DISPENSED BY ALL RELIABLE DRUGGISTS.

# THE URIC SOLVENT

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(Author of the VIBURNUM COMPOUND,)

Has proved to be a most satisfactory prescription in the hands of the profession in cases dependent upon an imperfect action of the kidneys, and in all diseases arising from an excess of Uric Acid in the blood, especially incipient *Bright's Disease*, *Calculi*, *Cystitis*, *Dropsy*, *Gout*, *Neuralgia*, *Rheumatism*, *Angina Pectoris*, *Diseases of the heart and Paralysis*. Dr. Hayden's theory being that Uric Acid acts only on the conductivity of the nerves, promoting the complaints named. Physicians will find the URIC SOLVENT a valuable helper of all renal disorders, being perfectly safe and without disagreeable sequelæ. For Special Circular containing formula, reports of cases, directions, and testimonials, send your address to the

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BEDFORD SPRINGS, MASS.

Dispensed by all Reliable Apothecaries.

Put up in Twelve-Ounce Bottles.

PRICE, ONE DOLLAR.

Our limited space will only allow us to append the following strong endorsements, which are a sample of a great many:

S. W. BOGAN, M. D., 421 G St., Washington, D. C., says: "I tried all our stock remedies in my own case of Rheumatism without benefit. I have now taken three bottles of the **URIC SOLVENT**, and am well."

S. W. SHEPHARD, M. D., Troy, Bradford County, Pa., writes under date of April 4th, 1889: "The **URIC SOLVENT** did splendidly for spasms of the bladder in an old carcinoma of the uterus."

Prof. W. C. WILE, M. D., editor of the *New England Medical Monthly*, writing from Danbury, Conn., under date of April 8th, in answer to our inquiry as to his experience with the URIC SOLVENT, says: "My Dear Doctor: In reply to your letter of the 5th, in regard to the use of the **URIC SOLVENT**, that I have been more than satisfied with its effects. The most notable results I got in a case of chronic inflammation of the bladder, with great atrophy, accompanied with lithiasis. After four months persistent treatment I obtained a complete cure."

Remember to mention this publication.

# WAGNER'S INFANT FOOD

## FORMULA.

Water and Volatile Substances.

Salts, especially Alkalies and Earth.

Milk and Vegetable Fats.

Milk Albuminates and Vegetable Albuminates, 18%.

Soluble Carbohydrates.

Cellulose in small quantity.

So treated and peptonized that only a small change is requisite to transform it into living blood in the Infant, Child or Invalid.

## AS A NUTRITIOUS FOOD.

**For Infants and Children.**—A reliable substitute for mother's milk, and sure preventive against cholera infantum.

**For Invalids**—Persons suffering with, or recovering from low fevers, those afflicted with cancer, or with any intestinal disorder, it will prove nourishing and comforting.

**For Dyspeptics**—Palatable and digestible.

**For the Aged**—Strengthening and pleasing.

**For Nursing Mothers**—Nourishing and sustaining.

## REQUIRES VERY LITTLE PREPARATION.

### DIRECTIONS FOR USE.

**For Infants, Children, Invalids, Dyspeptics, the Aged, and Nursing Mothers**—Dissolve one even tablespoonful in a half pint of cold water and boil for two minutes, *continually stirring to prevent burning*, and strain. Should be lukewarm when taken. A reliable substitute for mother's milk. **Does not constipate.** To increase the already appetizing flavor, four tablespoonfuls of good milk could be added before boiling, but it is quite unnecessary. Small quantity of sugar can be added to suit taste, but this is not necessary.

## KEEPS IN ALL CLIMATES.

I take pleasure in stating that the chemical and pharmaceutical preparations made by Wm. C. Wagner are worthy the confidence of all persons who have occasion to buy the best articles. As Mr. Wagner is a well trained chemist, a graduate of the Heidelberg College of Pharmacy, and a skillful druggist, his products are well worthy of trial in the public institutions, as well as by practicing physicians. ELISHA HARRIS, M. D.,  
Late Sanitary Superintendent of the Metropolitan District, New York, U.S.A.

**Prepared by WM. C. WAGNER, Chemist,  
BROOKLYN, N. Y.**

Circulars and Samples sent to Physicians on application.

**FOR SALE BY ALL DRUGGISTS.**



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WITH

## **COD LIVER OIL**

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*A combination of the best Norwegian Cod Liver Oil  
with MALTINE, in which, by the vacuum  
process, rancidity is prevented and  
disagreeable odor and taste  
of the oil removed.*

**Base a Powerful Reconstructive**

**Contains No Inert Emulsifier**

**Does not disturb Digestion nor offend the Palate**

Is an active Starch Digester and Tissue Builder.

Produces rapid Improvement in Appetite.

Is used where "Emulsions" cannot be tolerated.

A complete list of the Maltine Preparations and their formulae will be sent on application.

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New York, N. Y.

# Dr. J. B. S. HOLMES' PRIVATE SANITARIUM

## FOR DISEASES OF WOMEN.



**M**Y PRIVATE SANITARIUM for the treatment of Medical and Surgical Diseases of Women will be open for the reception of patients

**OCTOBER 1st NEXT, (1891.)**

The Building is large and handsome, and is being constructed especially for the purpose for which it is to be used. The grounds, about five acres, are beautifully shaded and are very attractive. The Rooms are all of good size, thoroughly ventilated, and each has an open grate, large closet, gas and electric bells, inside and outside blinds, double hung sash and transoms over all doors.

The entire Building, except the Surgical Division, will be handsomely carpeted and beautifully furnished. Water closets, with hot and cold baths, on each floor; hot and cold water at twelve different places in the halls.

### **NO WATER PIPES IN BED ROOMS.**

The drainage is as near perfect as Sanitary science will make it. The house-keeping will be in charge of a most **Cultured and Experienced Lady**, who is widely known for her excellence and superior merit in this particular. The

### **CUISINE SHALL BE THE VERY BEST,**

and the service in every respect as good as it can be made.

### **A MATERNITY DEPARTMENT,**

Where everything will be as near **ASEPTIC** as possible, in charge of nurses educated and trained especially for this purpose, will be an especial feature of the Institution.

### **THE SURGICAL DEPARTMENT,**

Under same roof but disconnected with the main building, will be made as near **ASEPTIC** as it can be. I have a full corps of competent Physicians to assist me. A resident Physician, with a cottage on the grounds, will be in constant attendance. My nurses are all ladies of education and training in their profession, most of them coming direct from the Woman's Hospital, New York.

I refer by permission to Dr. G. W. MULLIGAN, President Georgia State Medical Association, Washington, Ga.; Drs. J. S. TODD and A. W. CALHOUN, ex-Presidents Georgia State Medical Association, Atlanta, Ga. Also the following gentlemen, Censors Georgia State Medical Association: Drs. EUGENE FOSTER, Augusta, Ga.; B. R. DOSTER, Blakely, Ga.; MARK H. O'DANIEL, Milledgeville, Ga.; K. P. MOORE and H. McHATTON, Macon, Ga., or any member in good **STANDING** of the Georgia State Medical Association.

Physicians sending me patients may rest assured that they will receive the best care and attention in every particular, and reports will be made every few days. Special rates will be made for the wives and daughters of Physicians and Clergymen.

For further information, terms, etc., address

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# DRUGS THAT LIVE . . . .

Are few in number compared to the enormous increase of claimants for the physician's approval. The active practitioner can not afford to risk success by leaving the safe harbor of tried and approved remedies, to follow the leadings of every alleged new remedy brought to his notice through "worked up" testimonials, adroitly presented to catch the unwary.

*"It requires a long and careful study to determine the true value of the old, and still longer to test a new medicine."*

## GOLDEN SEAL

The representative American remedy, in all its varied forms—is one of the "drugs that live," and its place in medicine is so firmly established, both in America and Europe, that the physician who does not give it a place in his medicine case fails to fully avail himself of his opportunities to combat disease with the best means at his command.

## FLUID HYDRASTIS

MERRELL

Was originated and introduced by The Wm. S. Merrell Chemical Co., and **the one** perfect representative of the drug in fluid form.

Is what its name applies—the active medicinal principles of the drug in natural combination and in a fluid form.

Has a bright yellow color; perfectly clear; free from sediment; and with an unmistakable odor of the *fresh* drug.

Is a pure, neutral solution of all the alkaloidal constituents of the drug; rejecting the oil, gum, irritating and offensive resins; and inert extractive matters.

Is indicated in all affections of the mucous surfaces, correcting abnormal conditions characterized by profuse discharge of tenacious mucous, sub-acute inflammation, erosions and superficial ulcerations.

**FLUID HYDRASTIS** Is used in gonorrhea, leucorrhea, ulceration of the cervix uteri and vagini, cystitis, nephritis, stomatitis, dyspepsia, constipation, opthalmi taasi, conjunctivitis, catarrh of the intestines, painful menstruation, and as a local application to prevent decomposition, as an injection into the bowels in diarrhea and dysentery, and to correct the offensive character of many mucous discharges.

**FORMS A CLEAR SOLUTION WITH ALCOHOL, GLYCERIN, SYRUP, WINE OR WATER.**

"LABORATORY NOTES" review the Hydrastis subject thoroughly, and consider the associated preparations "Solution Bismuth and Hydrastia" and "Colorless Hydrastia."  
Copies supplied without charge.

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# SYRUP OF FIGS,

(Syr. Fici Cal.)

In order to meet the almost universal demand for a safe, reliable and elegant liquid laxative, the

## CALIFORNIA FIG SYRUP CO.,

—OF—

SAN FRANCISCO, CAL.,

LOUISVILLE, KY.,

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Is utilizing the delicious Blue Fig of California in the preparation of

## SYRUP OF FIGS,

An agreeable and effective laxative or purgative according to the dose and manner of administration.

Syrup of Figs is delightful to the taste and may be taken by every one from infancy to old age.

Syrup of Figs does not debilitate and is perfectly safe.

The dose as a purgative for an adult is from one-half to one tablespoonful, and may be repeated in six hours if required. As a laxative, one or two teaspoonfuls may be given at bed time, or before breakfast.

For children, the dose may be regulated according to the age and desired effect.

## SYRUP OF FIGS

Is recommended and prescribed by prominent physicians in all sections of the United States and gives general satisfaction.

In addition to the Blue Figs of California, we use the juice of true Alexandria Senna, representing the laxative and purgative principles without its griping properties, also pure white sugar and an excellent combination of carminative aromatics.

Devoting our entire attention to the manufacture of Syrup of Figs after thorough study of the results to be accomplished and of the best methods to produce a perfect laxative, and with complete manufacturing facilities especially adapted to the purpose, we are enabled to offer to the medical profession, in Syrup of Figs, a laxative which though simple in itself, cannot be produced in all its excellence by other parties, and we believe and trust that physicians will not permit imitations to be used when they prescribe Syrup of Figs (Syr. Fici Cal.)

Syrup of Figs is manufactured only by the

## CALIFORNIA FIG SYRUP CO.,

—OF—

SAN FRANCISCO, CAL.,

Louisville, Ky.,

New York, N. Y.

It is sold to the drug trade in bottles of two sizes only; the smaller bottles containing full four oz., and the large size about ten oz.

 Mention this publication.

# WAYNE'S \* DIURETIC \* ELIXIR.

*Composed of Buchu, Juniper, Acetate of 'Potash, Etc.]*

## DIURETIC AND ALTERATIVE.

**INDICATIONS.**—Acute and Chronic Catarrh of the Bladder. Brick Dust and Chalky Deposits in the Urine, Gravel, etc. Acute and Chronic Bright's Disease, Lumbago, and in Acute and Chronic Rheumatism.

Prescribed and endorsed by the leading physicians of the United States. It is giving universal satisfaction in the profession. It seems to be ALMOST A SPECIFIC for Diseases of the Genito-Urinary Organs.

*Extract from letter, W. F. Glenn, M. D., Professor of Genital-Urinary Diseases in the Medical Department of the University of Tennessee.*

No practitioner passes many days, or seldom many hours, without being called upon to prescribe for some real or imaginary disease of the kidneys. While such serious disorders as diabetes and Bright's disease, in which these organs are fatally involved, are occasionally met with, they are few as compared with the many minor affections, not only in the kidneys themselves, but on all parts of the genito-urinary tract. Catarrh of the kidneys, ureter, bladder or urethra, irritations and congestions of the various parts of the urinary apparatus, are as common as bad colds. What is more frequent than patients complaining of pain in the back, in the region of the kidneys, with or without a scant flow of urine, or a burning sensation in the neck of the bladder or urethra on voiding urine, and numbers of other similar ailments. In all forms of functional derangements of these important excretory organs the administration of a gentle but effective diuretic generally affords relief. Where an analysis of urine proves the absence of elements that would indicate serious organic lesions it is safe, and in fact, a proper course to use a remedy that will stimulate to gentle action the cells of the kidneys, thereby increasing the watery portions of the urine. Such a course will rarely fail to effect a cure.

For this purpose there is nothing superior to buchu, juniper, acetate or potash, corn silk and digitalis. The action of many of this class of remedies, such as corn silk, juniper, eucalyptus, etc., have a more or less specific influence on bladder and urethral irritations and inflammations.

Some years since my attention was attracted to a remedy styled Wayne's Diuretic Elixir, which, upon examination, I found to be a combination of acetate of potash, juniper and buchu, prepared in such a manner as not to be unpleasant, but rather agreeable to the taste, and accurate in its proportions. Being easier to prescribe and far more pleasant to the patient than the same remedies freshly mixed in the drug store, I began to use it in all irritations of the kidneys, bladder, urethra and prostate gland, and have found it to meet every indication. Now, when I desire a mild diuretic effect continued for some time, I rarely depart from this mixture. Prof. Deering J. Roberts, surgeon to the State Prison, has been using it largely of late at the hospital of that institution, and reports it perfectly satisfactory. Case after case taken from my own and from other record books could be cited to show its satisfactory effects, but that is hardly necessary. And while I am not an advocate of the wholesale use of all the various preparations that are now crowded upon us, at the same time, after thoroughly testing this one for some years, I feel that it will not be amiss to present its virtues to the profession. Not for any new virtues that its ingredients may possess, for they have been understood for many years, but because of its careful preparation and pleasant taste, and thereby great utility. From the very highly satisfactory results obtained by me for the past five years, I am quite sure its use will be attended with no disappointment or regret.


*Extract from letter Dr Theo. Jasper, 322 South Sixth street, Columbus, Ohio.*

COLUMBUS, Ohio, January 21, 1886.—Wayne Elixir Company—Gentlemen: Regarding your most excellent preparation, "The Wayne's Diuretic and Alterative Elixir," I am happy to say that I have used it in my practice for over two years in hundreds of cases, and in every case I used it it gave perfect satisfaction. The effect of its action can be perceived immediately, and in most cases only a small quantity, five or six ounces, was needed to effect a complete cure; it is, besides, not unpleasant to the taste, and is borne by the most delicate stomach. Truly and most respectfully yours,

THEODORE JASPER, M. D., 322 South Sixth Street.

**SPECIAL TO PHYSICIANS.**—We will send, upon application, one bottle, containing 12 ounces, regular size (retails at \$1) FREE FOR TRIAL to those physicians who will pay express charges. Address

**WAYNE ELIXIR COMPANY,  
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# BROMIDIA

## THE HYPNOTIC.

### FORMULA.—

Every fluid drachm contains fifteen grains EACH of Pure Chloral Hydrat. and purified Brom. Pot. and one-eighth grain EACH of gen. im. ext. Cannabis Ind. and Hyoscyam.

### DOSE.—

One-half to one fluid drachm in WATER or SYRUP every hour, until sleep is produced.

### INDICATIONS.—

Sleeplessness, Nervousness, Neuralgia, Headache, Convulsions, Colic, Mania, Epilepsy, Irritability, etc. In the restlessness and delirium of fevers it is absolutely invaluable.

**IT DOES NOT LOCK UP THE SECRETIONS.**

# PAPINE

## THE ANODYNE.

Papine is the Anodyne or pain-relieving principle of Opium, the Narcotic and Convulsive Elements being eliminated.

It has less tendency to cause Nausea, Vomiting, Constipation, Etc.

### INDICATIONS.—

Same as Opium or Morphia.

### DOSE.—

ONE FLUID DRACHM—(represents the Anodyne principle of one-eighth grain of Morphia.)

# IODIA

## THE ALTERATIVE AND UTERINE TONIC.

### FORMULA.—

Iodia is a Combination of active principles obtained from the Green Roots of Stillingia, Helonias, Saxifraga, Menispermum and Aromatics. Each fluid drachm also contains five grains Iod. Potas., and three grains Phos. Iron.

### DOSE.—

One or two fluid drachms (more or less as indicated) three times a day, before meals.

### INDICATIONS.—

Syphilitic, Scrofulous and Cutaneous Diseases, Dysmenorrhea, Menorrhagia, Leucorrhoea, Amenorrhoea, Impaired Vitality, Habitual Abortions and General Uterine Debility.

SPECIFY "BATTLE" WHEN PRESCRIBING OUR PREPARATIONS.

SPECIFY "BATTLE" WHEN PRESCRIBING OUR PREPARATIONS.



## PEPTONOIDS BEEF (POWDER.)

STERILIZED


**BEEF  
MILK  
CLUTEN**


PARTIALLY PEPTONIZED.

### THE MOST CONCENTRATED AND NUTRITIOUS FOOD IN THE MARKET.

*Received the only GOLD MEDAL and Highest Award at the International Health Exhibition, London, after a critical Examination of all the Beef and Concentrated Food Productions, by a Jury composed of the Best Chemists in Europe.*

There is no food preparation that compares with it in nutritive properties.

It is partially prepared for assimilation, and, therefore, makes less demand upon the digestive powers of the gastric juice.

Being in the form of a dry powder and *sterilized*, it will keep in any climate. It contains 95 per cent. of nutritious matter.

The use of BEEF PEPTONOIDS is indicated as follows:

Convalescence from all diseases, Pulmonary Affections, Pneumonia, Phthisis, Dyspepsia, Gastritis, and all Stomach Ailments: Fevers, Diarrhœa, Dysentery, and all Intestinal Diseases; Marasmus, Bright's Disease, Diabetes and Excessive Use of Alcoholic Stimulants. Beef Peptonoids may be given per rectum in all cases where the stomach cannot digest food, and in Debility resulting from any cause.

## PEPTONOIDS LIQUID.

This preparation represents Beef Peptonoids in the form of an elegant cordial, all constituents being entirely digested and ready for assimilation.

Liquid Peptonoids is a nourishing peptogenic liquid stimulant with the albuminoids in a soluble state with only sufficient spirits added to preserve it. It contains the largest amount of albuminoid principles and the least amount of alcohol that is possible to use and make a stable compound.

Liquid Peptonoids will keep indefinitely; its flavor and palatability are such that many who have taken it liken it to a delicate cordial. It will readily be taken by patients who are unable to digest food in any other form (in these cases it has been found of the greatest service). In convalescence from fever and other diseases, in loss of appetite, weak digestion and gastritis its effects are positive, and it will never fail to give perfect satisfaction.

There is no preparation in the market that has been recommended so highly by physicians who have carefully tested it.

**DOSE.**—For an adult, one tablespoonful three times to six times a day; children in proportion.

## PHOSPHO-CAFFEIN COMP.

(GRANULAR EFFERVESCING.)

### A SEDATIVE NERVE AND BRAIN FOOD.

The most efficient and palatable preparation in **Nervous and Sick Headache, Neuralgia, Insomnia, Neurasthenia and General Nervous Irritability.**

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

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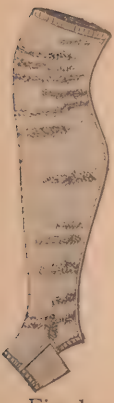


Fig. 1.

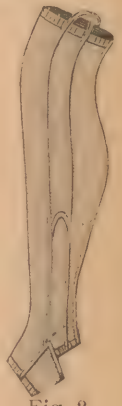


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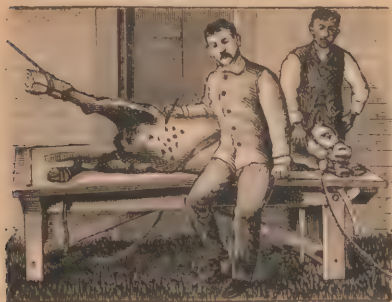
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**DR. JOHN AULDE**, of Philadelphia, Pa. "Hydrogen Dioxide a Resumé." *New York Medical Journal*.

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William M. Johnson,	Dec. 30, 1889,	Jan. 5, 1890,		Gustav Thoman,	Jan. 21, 1890,	Jan. 23, 1890,	

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The representative American remedy, in all its varied forms—is one of the "drugs that live," and its place in medicine is so firmly established, both in America and Europe, that the physician who does not give it a place in his medicine case fails to fully avail himself of his opportunities to combat disease with the best means at his command.

FLUID

HYDRASTIS

MERRELL

Was originated and introduced by The Wm. S. Merrell Chemical Co., and is **the one** perfect representative of the drug in fluid form.

Is what its name applies—the active medicinal principles of the drug in natural combination and in a fluid form.

Has a bright yellow color; perfectly clear; free from sediment; and with an unmistakable odor of the *fresh drug*.

Is a pure, neutral solution of all the alkaloidal constituents of the drug; rejecting the oil, gum, irritating and offensive resins; and inert extractive matters.

Is indicated in all affections of the mucous surfaces, correcting abnormal conditions characterized by profuse discharge of tenacious mucous, sub-acute inflammation, erosions and superficial ulcerations.

## FLUID HYDRASTIS

Is used in gonorrhea, leucorrhea, ulceration of the cervix uteri and vagini, cystitis, nephritis, stomatitis, dyspepsia, constipation, ophthalmi taasi, conjunctivitis, catarrh of the intestines, painful menstruation, and as a local application to prevent decomposition, as an injection into the bowels in diarrhea and dysentery, and to correct the offensive character of many mucous discharges.

FORMS A CLEAR SOLUTION WITH ALCOHOL, GLYCERIN, SYRUP, WINE OR WATER.

"LABORATORY NOTES" review the Hydrastis subject thoroughly, and consider the associated preparations "Solution Bismuth and Hydrastia" and "Colorless Hydrastia."

Copies supplied without charge.

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New Orleans, La.

THE WM. S. MERRELL CHEMICAL CO.,  
MANUFACTURING CHEMISTS,  
CINCINNATI AND NEW YORK.

# SYRUP OF FIGS,

(Syr. Fici Cal.)

In order to meet the almost universal demand for a safe, reliable and elegant liquid laxative, the

## CALIFORNIA FIG SYRUP CO.,

—OF—

SAN FRANCISCO, CAL.,

LOUISVILLE, KY.,

NEW YORK, N. Y.,

Is utilizing the delicious Blue Fig of California in the preparation of

## SYRUP OF FIGS,

An agreeable and effective laxative or purgative according to the dose and manner of administration.

Syrup of Figs is delightful to the taste and may be taken by every one from infancy to old age.

Syrup of Figs does not debilitate and is perfectly safe.

The dose as a purgative for an adult is from one-half to one tablespoonful, and may be repeated in six hours if required. As a laxative, one or two teaspoonfuls may be given at bed time, or before breakfast.

For children, the dose may be regulated according to the age and desired effect.

## SYRUP OF FIGS

Is recommended and prescribed by prominent physicians in all sections of the United States and gives general satisfaction.

In addition to the Blue Figs of California, we use the juice of true Alexandria Senna, representing the laxative and purgative principles without its griping properties, also pure white sugar and an excellent combination of carminative aromatics.

Devoting our entire attention to the manufacture of Syrup of Figs after thorough study of the results to be accomplished and of the best methods to produce a perfect laxative, and with complete manufacturing facilities especially adapted to the purpose, we are enabled to offer to the medical profession, in Syrup of Figs, a laxative which though simple in itself, cannot be produced in all its excellence by other parties, and we believe and trust that physicians will not permit imitations to be used when they prescribe Syrup of Figs (Syr. Fici Cal.)

Syrup of Figs is manufactured only by the

## CALIFORNIA FIG SYRUP CO.,

—OF—

SAN FRANCISCO, CAL.,

Louisville, Ky.,

New York, N. Y.

It is sold to the drug trade in bottles of two sizes only; the smaller bottles containing full four oz., and the large size about ten oz.

 Mention this publication.

# WAYNE'S \* DIURETIC \* ELIXIR.

*Composed of Buchu, Juniper, Acetate of Potash, Etc.*

## DIURETIC AND ALTERNATIVE.

**INDICATIONS.**—Acute and Chronic Catarrh of the Bladder. Brick Dust and Chalky Deposits in the Urine, Gravel, etc. Acute and Chronic Bright's Disease, Lumbago, and in Acute and Chronic Rheumatism.

Prescribed and endorsed by the leading physicians of the United States. It is giving universal satisfaction in the profession. It seems to be **ALMOST A SPECIFIC** for Diseases of the Genito-Urinary Organs.

*Extract from letter, W. F. Glenn, M. D., Professor of Genital-Urinary Diseases in the Medical Department of the University of Tennessee.*

No practitioner passes many days, or seldom many hours, without being called upon to prescribe for some real or imaginary disease of the kidneys. While such serious disorders as diabetes and Bright's disease, in which these organs are fatally involved, are occasionally met with, they are few as compared with the many minor affections, not only in the kidneys themselves, but on all parts of the genito-urinary tract. Catarrh of the kidneys, ureter, bladder or urethra, irritations and congestions of the various parts of the urinary apparatus, are as common as bad colds. What is more frequent than patients complaining of pain in the back, in the region of the kidneys, with or without a scant flow of urine, or a burning sensation in the neck of the bladder or urethra on voiding urine, and numbers of other similar ailments. In all forms of functional derangements of these important excretory organs the administration of a gentle but effective diuretic generally affords relief. Where an analysis of urine proves the absence of elements that would indicate serious organic lesions it is a safe, and in fact, a proper course to use a remedy that will stimulate to gentle action the cells of the kidneys, thereby increasing the watery portions of the urine. Such a course will rarely fail to effect a cure.

For this purpose there is nothing superior to buchu, juniper, acetate of potash, corn silk and digitalis. The action of many of this class of remedies, such as corn silk, juniper, eucalyptus, etc., have a more or less specific influence on bladder and urethral irritations and inflammations.

Some years since my attention was attracted to a remedy styled Wayne's Diuretic Elixir, which, upon examination, I found to be a combination of acetate of potash, juniper and buchu, prepared in such a manner as not to be unpleasant, but rather agreeable to the taste, and accurate in its proportions. Being easier to prescribe and far more pleasant to the patient than the same remedies freshly mixed in the drug store, I began to use it in all irritations of the kidneys, bladder, urethra and prostate gland, and have found it to meet every indication. Now, when I desire a mild diuretic effect continued for some time, I rarely depart from this mixture. Prof. Deering J. Roberts, surgeon to the State Prison, has been using it largely of late at the hospital of that institution, and reports it perfectly satisfactory. Case after case taken from my own and from other record books could be cited to show its satisfactory effects, but that is hardly necessary. And while I am not an advocate of the wholesale use of all the various preparations that are now crowded upon us, at the same time, after thoroughly testing this one for some years, I feel that it will not be amiss to present its virtues to the profession. Not for any new virtues that its ingredients may possess, for they have been understood for many years, but because of its careful preparation and pleasant taste, and thereby great utility. From the very highly satisfactory results obtained by me for the past five years, I am quite sure its use will be attended with no disappointment or regret.

*Extract from letter Dr Theo. Jasper, 322 South Sixth street, Columbus, Ohio.*

COLUMBUS, Ohio, January 21, 1886.—Wayne Elixir Company—Gentlemen: Regarding your most excellent preparation, "The Wayne's Diuretic and Alternative Elixir," I am happy to say that I have used it in my practice for over two years in hundreds of cases, and in every case I used it gave perfect satisfaction. The effect of its action can be perceived immediately, and in most cases only a small quantity, five or six ounces, was needed to effect a complete cure; it is, besides, not unpleasant to the taste, and is borne by the most delicate stomach. Truly and most respectfully yours,

THEODORE JASPER, M. D., 322 South Sixth Street.

**SPECIAL TO PHYSICIANS.**—We will send, upon application, one bottle, containing 12 ounces, regular size (retails at \$1) FREE FOR TRIAL to those physicians who will pay express charges. Address

**WAYNE ELIXIR COMPANY,  
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# BROMIDIA

## THE HYPNOTIC.

### FORMULA.—

Every fluid drachm contains fifteen grains EACH of Pure Chloral Hydrat, and purified Brom. Pot. and one-eighth grain EACH of gen. im. ext. Cannabis Ind. and Hyoscyam.

### DOSE.—

One-half to one fluid drachm in WATER or SYRUP every hour, until sleep is produced.

### INDICATIONS.—

Sleeplessness, Nervousness, Neuralgia, Headache, Convulsions, Colic, Mania, Epilepsy, Irritability, etc. In the restlessness and delirium of fevers it is absolutely invaluable.

**IT DOES NOT LOCK UP THE SECRETIONS.**

# PAPINE

## THE ANODYNE.

Papine is the Anodyne or pain-relieving principle of Opium, the Narcotic and Convulsive Elements being eliminated.

It has less tendency to cause Nausea,  
Vomiting, Constipation, Etc.

### INDICATIONS.—

Same as Opium or Morphia.

### DOSE.—

ONE FLUID DRACHM—(represents the Anodyne principle of one-eighth grain of Morphia.)

# IODIA

## THE ALTERATIVE AND UTERINE TONIC.

### FORMULA.—

Iodia is a Combination of active principles obtained from the Green Roots of Stillingia, Helonias, Saxifraga, Menispermum and Aromatics. Each fluid drachm also contains five grains Iod. Potas., and three grains Phos. Iron.

### DOSE.—

One or two fluid drachms (more or less as indicated) three times a day, before meals.

### INDICATIONS.—

Syphilitic, Scrofulous and Cutaneous Diseases, Dysmenorrhea, Menorrhagia, Leucorrhœa, Amenorrhea, Impaired Vitality, Habitual Abortions and General Uterine Debility.

SPECIFY "BATTLE" WHEN PRESCRIBING OUR PREPARATIONS.

SPECIFY "BATTLE" WHEN PRESCRIBING OUR PREPARATIONS.

## PEPTONOIDS BEEF (POWDER.)

STERILIZED


**BEEF  
MILK  
CLUTEN**


PARTIALLY PEPTONIZED.

### THE MOST CONCENTRATED AND NUTRITIOUS FOOD IN THE MARKET.

*Received the only GOLD MEDAL and Highest Award at the International Health Exhibition, London, after a critical Examination of all the Beef and Concentrated Food Productions, by a Jury composed of the Best Chemists in Europe.*

There is no food preparation that compares with it in nutritive properties.

It is partially prepared for assimilation, and, therefore, makes less demand upon the digestive powers of the gastric juice.

Being in the form of a dry powder and *sterilized*, it will keep in any climate. It contains 95 per cent. of nutritious matter.

The use of BEEF PEPTONOIDS is indicated as follows:

Convalescence from all diseases, Pulmonary Affections, Pneumonia, Phthisis, Dyspepsia, Gastritis, and all Stomach Ailments; Fevers, Diarrhœa, Dysentery, and all Intestinal Diseases; Marasmus, Bright's Disease, Diabetes and Excessive Use of Alcoholic Stimulants. Beef Peptonoids may be given per rectum in all cases where the stomach cannot digest food, and in Debility resulting from any cause.

## PEPTONOIDS LIQUID.

This preparation represents Beef Peptonoids in the form of an elegant cordial, all constituents being entirely digested and ready for assimilation.

Liquid Peptonoids is a nourishing peptogenic liquid stimulant with the albuminoids in a soluble state with only sufficient spirits added to preserve it. It contains the largest amount of albuminoid principles and the least amount of alcohol that is possible to use and make a stable compound.

Liquid Peptonoids will keep indefinitely; its flavor and palatability are such that many who have taken it liken it to a delicate cordial. It will readily be taken by patients who are unable to digest food in any other form (in these cases it has been found of the greatest service). In convalescence from fever and other diseases, in loss of appetite, weak digestion and gastritis its effects are positive, and it will never fail to give perfect satisfaction.

There is no preparation in the market that has been recommended so highly by physicians who have carefully tested it.

**DOSE.**—For an adult, one tablespoonful three times to six times a day; children in proportion.

## PHOSPHO-CAFFEIN COMP.

(GRANULAR EFFERVESCENT.)

### A SEDATIVE NERVE AND BRAIN FOOD.

The most efficient and palatable preparation in Nervous and Sick Headache, Neuralgia, Insomnia, Neurasthenia and General Nervous Irritability.

Each dessertspoonful contains: Caffein. Acidi Phosphorici,  $\overline{\text{aa}}$  grains, ss. Antipyrin. Ext. Apii.  $\overline{\text{Grav. Dulc.}}$  (Celery)  $\overline{\text{aa}}$  grain j. Sodium Bromide, grains v.

**DOSE.**—One or two heaping teaspoonfuls in a half tumbler of water. Put up in 4 oz. and 8 oz. Bottles.

## THE ARLINGTON CHEMICAL CO.,

*Successors to REED & CARRICK for the above preparations.*

YONKERS, N. Y.

# PONCA COMPOUND

*A Uterine Alterative Especially  
Affecting the Mucous Surfaces.*

## INDICATIONS:

**Metritis,  
Endo-Metritis,  
Subinvolution,  
Menorrhagia,  
Metrorrhagia,  
Leucorrhœa,  
Dysmenorrhœa,  
Ovarian Neuralgia,  
Threatened Abortion,  
Suppressed Menses,  
Painful Pregnancy,  
After-Pains.**

"Ponca Compound exercises a decided and specific alterative action upon the uterine tissues as also a general tonic influence upon the Pelvic Organs:—It has a tendency to absorb plastic deposits, to regulate the vascular supply, to relieve congestion, to tone up the nerve forces, to regulate the bowels, and to remove spasmodic conditions. In most instances it eradicates the principal influences that cause and keep up engorgements, displacements, etc., and can always be relied upon as the chief factor in bringing about normal conditions."

EACH TABLET CONTAINS EXT. PONCA, 3 GRs.; EXT. MITCHELLA REPENS, 1 GR.; CAULOPHYLLIN,  $\frac{1}{4}$  GR.; HELONIN,  $\frac{1}{4}$  GR.; VIRBURNIN,  $\frac{1}{4}$  GR.

Ponca is a small plant growing on the south-western prairies and is used by the Indian women for troubles of the uterus and its appendages, on account of a strong alterative action.

100 TABLETS WILL BE MAILED UPON RECEIPT OF \$1.00

## MELLIER DRUG COMPANY

109 Walnut Street, ST. LOUIS.



**PURE FOOD FOR PATIENTS.**

CREAM KUMYSS is retained and assimilated in cases where everything else fails.



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INALTERABLE

AMERICAN MILK AND KUMYSS CO.

8 & 10 HORATIO ST., NEW YORK.

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*The Best Nourishing  
and Refreshing Drink.*

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*Its Quality Improves  
with Age.*

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*No Ice Required to  
Keep It.*

**The only Kumyss guaranteed to keep any length of time, may be shipped all over the world.**

ATTESTATIONS: We beg to call the attention of the profession to the following certificates, among many others that we have received from prominent doctors and chemists:

American Milk and Kumyss Co.,

Gentlemen: This is to certify that I have carefully examined CREAM KUMYSS, and find it to be free from adulteration of any kind. It is my opinion that it is the best article of its kind in the market.

New York, June 22, 1891.

Chief Inspector at the Board of Health of the City of New York,

New York, June 25, 1891.

Gentlemen: This is to certify that your preparation known as the CREAM KUMYSS contains no chemical substance foreign to pure milk, and furthermore, that its susceptibility of keeping, without spoiling, is only due to the purity of the milk and the excellent scientific precautions used in the process of fermentation.

PAUL GIBIER, M. D.,

President of the New York Bacteriological and Pasteur Institute.

For sale at all the leading Druggists. Send for circular.

**AMERICAN MILK & KUMYSS CO. - 8 & 10 HORATIO ST., NEW YORK.**



# LAPACTIC PILLS

A combination introduced by us and found in practice to possess superior advantages over other similar formulæ.

The well-known mild action of Aloin on the lower portion of the intestinal canal, and its power of stimulating the hepatic functions, is supplemented by the action of Ipecac as a stomachic tonic and by increasing the gastric secretions; the Belladonna acts specially upon the involuntary muscular fibres of the bowels, increasing peristalsis, diminishing the harshness and at the same time increasing the effectiveness of the laxative. The general tonic effect of Starchnine upon the stomach and bowels, and its direct action upon the sympathetic make it a valuable addition in the permanent cure of

## HABITUAL CONSTIPATION AND ATONIC DYSPEPSIA.

Since we first called attention to our Lapactic Pills, some four years ago, publishing the composition of the same, a number of manufacturers have adopted the same formula and have furnished these pills under the same name. Should Physicians fail to obtain satisfactory results from Lapactic Pills not of our make (and we have received a large number of such complaints from physicians by letter), we shall be glad to furnish a sample of our Lapactic Pills on application. We feel confident that they will fully substantiate our claims.

Please use the term "**LAPACTIC PILLS, S. & D.'S.**" when prescribing these pills.

# Pan-Peptic Tablets S. & D.'s.


## A TONIC DIGESTIVE.

Pure Pepsin .....	1 gr.
Pure Pancreatin .....	1 gr.
Pure Caffeine .....	$\frac{1}{4}$ gr.
Acid Lacto-Phosphate of Calcium .....	
Celery,	

The **Pepsin** and **Pancreatin** used in these tablets possess highest digestive power, and cannot fail to promptly start and accomplish

## THE DIGESTION OF FOOD.

Whilst the **Caffeine**, by its stimulant tonic action on stomach and bowels, assists and quickens the normal digestion and assimilation of food, the **Acid Lacto-Phosphate of Calcium** contributes to the tonic action of the tablets, and aids to build up the general system, and a small quantity of that refreshing aromatic nerve stimulant, **Celery**, imparts a pleasant flavor and acts as an appetizer.

 SAMPLE SENT TO PHYSICIANS WHO MENTION THIS JOURNAL. 

# SHARP & DOHME,

MANUFACTURERS OF

STANDARD MEDICINAL FLUID AND SOLID EXTRACTS; SOLUBLE HYPODERMIC TABLETS; SOLUBLE GELATIN AND SUGAR-COATED PILLS AND GRANULES; GRANULAR EFFERVESCENT SALTS; COMPRESSED LOZENGES AND TABLETS; FINE CHEMICALS, &C.

ESTABLISHED 1860.

BALTIMORE, MD.

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# **TARRANT'S**

# **SELTZER APERIENT**

## **(EFFERVESCENT),**

**Prepared for the use of New York Physicians in 1844.**

### **The Most Efficacious and Palatable Aperient.**

Having used your Tarrant's Seltzer Aperient in my practice for the past twenty years, I can truthfully indorse it as the best Aperient I have ever prescribed for disorders of the stomach, dyspepsia and for constipation of pregnancy. In fact I know of no other Aperient to equal it.

I have recently found it a splendid vehicle for the administration of tincture of iron. It overcomes the constipating effect, neutralizes the acid so that it does not affect the teeth, and disguises the taste of the iron perfectly.

ALLEGHENY, August 13, 1890

S. W. BOGGS, M. D.

### **The Typical Saline in Rheumatic and Gouty Diathesis.**

Tarrant's Seltzer Aperient is an old and familiar remedy with me, having used it for thirty years in my practice. With me it has not been superseded for general purposes as a laxative by any of the waters or their saline constituents so much in vogue at the present day.

Its effervescent and palatable qualities especially adapt it to cases of irritable stomach, and its saline elements fit it peculiarly for cases of Gout, Rheumatism, Lithiasis, etc.

MARTIN LUTHER, M. D.

READING, PA., November 12, 1890.

### **The Ideal Remedy for the Constipation of Pregnancy.**

I have used Tarrant's Seltzer Aperient for the past twenty years in the constipation of pregnancy, and have found it an invaluable remedy for subduing constipation and entirely controlling morning sickness.

I fully indorse it as the best remedy I have ever used.

KANSAS CITY, Mo., April 23, 1890.

J. J. SMITH, M. D.

Tarrant's Seltzer Aperient is a medicine both palatable and efficacious, *made for and used by* the profession for nearly fifty years; it is worthy the attention of all physicians who are in search of a remedy that can always be relied upon, and is of special value owing to the wide range of cases in which it is applicable.



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**A SPRING AND SUMMER GRADUATING COURSE.**

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This instrument is capable of being shaped by the operator to fit each individual case, as the stem can be bent to any curve or angle.

Prominent Gynecologists, both in this country and in Europe, say it is the best pessary in use.

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THE special object of this line of tablets is to provide the profession with a convenient dosage form of the principal digestants, both alone and in combination as will allow of such varied selection as is adaptive to individual cases.

It is frequently found that a digestive ferment is greatly aided as to its effect by the concurrent action of other remedies: and on the other hand the action of a remedy is often accelerated and intensified by the synergistic aid of the digestants proper.

These tablets are NOT SUGAR COATED, hence are free from the well known objections arising from the use of cane sugar: they are also FREE FROM CHLORIDE OF SODIUM.

For the convenience of the prescriber Ford's Digestive Tablets are designated by numbers—when writing specify thus: Ford's D. T. Nos. I, II, etc.

## TABLET FORMULÆ.

I. Pepsin 1 grain and aromatics.

II. Pepsin and Bismuth—Pepsin 1 grain, subnitrate Bismuth 2 grains.

III. Pepsin, Bismuth and Strychnia—Pepsin 1 grain, subnitrate Bismuth 2 grains, Strychnia  $\frac{1}{10}$  grain.

IV. Pepsin, Bismuth and Charcoal—Pepsin 1 grain, Charcoal 2 grains, subnitrate Bismuth 2 grains.

V. Pepsin and Charcoal—Pepsin 1 grain, Charcoal 2 grains.

IV. Pepsin Comp.—Pepsin 1 grain, Pancreatin  $\frac{1}{2}$  grain, Lactophos. Line  $2\frac{1}{2}$  grains.

Packed in bottles containing 100 tablets at 75 cents per bottle.

In bottles containing 500 tablets at \$3.40 per bottle.

We prepare a special tablet No. VII, composed of Pancreatin,  $2\frac{1}{2}$  grains, and Sodium Bicarb.,  $7\frac{1}{2}$  grains, for peptonizing milk and other foods for infants and the sick. These tablets can be relied upon as always active, and require less skill in their use than other pancreatic preparations—an advantage appreciated by physicians because of the difficulty in having foods properly prepared by those who are not expert in such matters.

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This coupon entitles the sender to 100 Ford's Digestive Tablets of either variety, as first order, if accompanied with 25 cents for each kind ordered. One-cent postage stamps may be sent for amounts less than \$1. Mark or underscore such numbers on the coupon as are desired. Write address distinctly.

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The two { GOLDEN SCALE PEPSIN }  
FORD'S PEPSIN } Pepsins

continue to gain and retain the confidence of the medical profession.

These pepsins enable the physician to avail himself of the many uses found of late years for this dual principle of the gastric fluid.

**Golden Scale Pepsin** is freely soluble in water, especially useful for liquid forms.

**Ford's Pepsin** will not absorb the least moisture, and is convenient for dry forms.

Trial samples of Pepsin mailed free to any physician sending address.

New York & Chicago Chemical Co.,

96 and 98 Maiden Lane, NEW YORK, U. S. A.

Messrs. JOHN C. BAKER &amp; Co.

Gentlemen:

It affords me pleasure to have the opportunity of recommending your Cod Liver Oil to the medical profession. I feel satisfied that a purer and more efficacious article can not be obtained in the market.

Yours, with respect,

JOSEPH LEIDY,

*Professor of Anatomy in the University of Penna.*

## Baker's Pure Norwegian Cod Liver Oil.

Established 1830.

Put up in our capsuled bottles with steel engraved label. Will always be found of unequalled quality, and sure to yield the most satisfactory results.

OFFICE AND LABORATORY  
No 815 FILBERT STREET,  
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## Baker's Emulsion.

C. L. Oil with Hypo-phosphites. Made with our unequalled Norwegian Oil, rendering it by common consent the Best Emulsion in the market.

THE AMERICAN ANTIPYRETIC ANALGESIC & ANODYNE.  
A  
SUCCEDANEUM FOR MORPHIA.  
A NEW COMBINATION  
OF COAL TAR DERIVATIVES  
OF THE  
SERIES  $C_nH_{2n-6}$ .

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NEURALGIA, RHEUMATISM,  
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LA GRIPPE AND ALLIED COMPLAINTS IT  
SECURES THE DESIRED RESULT.

The GENUINE is put up in two forms only:—"POWDERED" AND "FIVE GRAIN TABLETS."

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# CELERINA

NERVE TONIC, STIMULANT AND ANTISPASMODIC.

**FORMULA.**—Every Fluid Drachm represents FIVE grains EACH—Celery, Coca, Kola, Viburnum and Aromatics.

**INDICATIONS.**—Loss of Nerve Power (so usual with Lawyers, Preachers, Writers and Business Men), Impotency, Spermatorrhea, Nervous Headache, Neuralgia, Paralysis, Hysteria, Opium Habit, Inebriety, Dyspepsia, and ALL LANGUID conditions of the System.

Indispensable to restore a patient after alcoholic excess.

**DOSE.**—One or two teaspoonfuls three or more times a day, as directed by the Physician.

# ALETRIS CORDIAL

UTERINE TONIC AND RESTORATIVE.

PREPARED FROM THE ALETRIS FARINOSA OR TRUE UNICORN.

**INDICATIONS.**—Amenorrhea, Dysmenorrhea, Leucorrhœa, Prolapsus Uteri, Sterility, to PREVENT Miscarriage, Etc.

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